Moss Family Dentistry

9095 N. Hess Street Suite 201
Hayden, Idaho
(208) 772-4500

Welcome to our office. Please read this information about our financial and billing policies.

If you DO NOT have insurance:

- You must pay at time of service or make prior arangements with our billing staff.
- We accept cash, personal checks, Mastercard, Visa, Discover, and CareCredit.

If you have insurance:

- We will gladly bill your insurance on your behalf, please provide all necessary information. This includes Insurance card and subscriber information.
- If your insurance requires Co-Payment, it is due at time of service.
- Even if you have insurance, payment to us is your responsibility.
- Balance on your account will be due upon receipt of your monthly statement.
- We may provide estimates for your treatment as a courtesy to you. However, all **insurance plans are unique**, and ultimately you are responsible for knowing your insurance benefits.
- We strongly encourage you to request records and X-rays from previous offices.
- Parents or legal guardian must accompany minors and are responsible for payments.

*** $25.00 charge for each returned or non-sufficient fund check.**
*** 1.5% per month finance charge on any balance over 60 days.**
*** $35.00 fee for not showing up to an appointment, or cancelling with less than 24 hour notice.**
*** Visits outside of regularly scheduled office hours may be subject to a $133.00 fee**

My signature below verifies that I have read and understand the above financial policy. I understand that regardless of insurance coverage, I am responsible for payment on my account.

Patient Consent for Use and Disclosure of Protected Health Information

Moss Family Dentistry may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. I have received and reviewed a copy of this office's Notice of Privacy Practices.

I have read and understand the above information. I understand that I am responsible (regardless of my insurance) for any charges incurred from services rendered or fees on my account.

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Patient Name (Please Print)

_____ _____

Authorized Signature (parent if minor) **Date**