Office & Financial Policies for the Rocky Mountain Prosthetic Dentistry, PC Office

Dr. Douglas Evans, DDS, MS and his staff would like to welcome you to our office. Our office strives to make your experience here as pleasant and as comfortable as possible. Please take a moment to review our office and financial policies.

Please feel free to discuss our fees with us at any time. Before any dental treatment is begun, the patient will receive an exam and/or consultation regarding any proposed treatment plan and cost. We will provide you with an estimate of insurance benefits at that time. The patient's estimated out of pocket cost will be due at the time services are rendered. Our office does accept cash, check, money order, Visa, Discover, and MasterCard. Our office also offers financing options for those who qualify through Care Credit. Eligible applicants may qualify for interest free financing with these companies.

As a courtesy to our patients with insurance, we will file your insurance claim to your primary insurance, allowing you to pay only your deductible and/or estimated co-payment/co-insurance as services are rendered. Please remember that the contract is between you and your insurance company and your total balance in our office is your responsibility regardless of any estimated insurance coverage. Our office makes every effort to give you an accurate estimate of what your portion of our fees will be based on the information provided to us by your insurance company. However, we have no way to guarantee the actual terms of your policy. If for any reason there is a balance remaining after your insurance company's payment, you will be sent a statement. If the insurance company has not paid the balance on your account within 30 days from the date of service, the balance will become due and a statement will be sent to you for payment. If requested, any overpayments will be refunded or the credit can remain on your account for future services. Our office will be more than happy to submit a pre-determination into your insurance if requested. Please allow 4-6 weeks for the insurance to process these requests thus, delaying treatment. Inform our front office staff if you would like this submitted.
All returned checks are subject to a $30.00 non-sufficient funds fee. All future payments will be required to be made by cash, credit card or money order only.
We will attempt to contact you regarding unpaid balances via phone and mail. If no effort has been made to clear any balance on the account, we will proceed with sending the account to a collection agency. Once the account has been turned over to an outside collection agency, any fees, court costs and attorney fees will be the patient/guarantor's sole responsibility. All future treatments will require payment in full by cash, credit card or money order only. Patients may request a copy of their records. Requests need to be in writing by the patient. Once our office receives this request, the records will be sent by email only.

Appointment Confirmation Policy:
To ensure efficiency of our appointment schedule, our office staff will contact you by telephone the day before your appointment. When the office cannot speak to you directly, they will leave a message asking you to call our office at 719-388-1818 to confirm your appointment. **Please note that if our office cannot contact you, or that you do not return the call to confirm, you will be removed from the schedule and a patient on our wait list will be substituted in your appointment time.** Our telephone system does not accept text messages.
We understand that your schedule may change, emergencies may happen, or that you simply forgot about an appointment you made for a dental cleaning 6 months ago. The telephone confirmation system reduces down time and opens more time slots for patients that may need immediate treatment. If you know you need to reschedule, please give us at least 24 hours notification.
I have been presented with the Rocky Mountain Prosthetic Dentistry's office and financial policy. I have been given the opportunity to read these policies. My signature below acknowledges that I have read, understand and agree to adhere to the financial policies outlined above. My signature below further acknowledges that my account is my sole responsibility and not dependant on insurance benefits.

Patient Signature:_____Date:_____
(Legal Guardian or parent if patient is a minor, under 18 yrs old)

Witnessed By:_____Date:_____
Receptionists and/or Assistant