WHITNEY M. FRANK
DDS

- Patient Financial Policy -

801 East Medical Court
Post Falls, ID 83854
Phone: 208.773.1559 Fax: 208.773.9959

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Patient Financial Policy. It is our hope, that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable, we are pleased to offer you the following payment options. *Please select one:*

1. Cash or Check
2. Visa, MasterCard or Discover
3. Care Credit

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office—this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within ninety (90) days of date of service, regardless of whether or not my insurance benefits have been received. One and a half percent (1.5%) per month interest, eighteen percent (18%) per year will be charged on accounts 30 days from the treatment date.

Please make your questions and concerns known to our Accounts Manager who is happy to discuss this policy and ensure that you have an outstanding experience.

_____ _____

Signature (Responsible Party) Date

FINANCIAL INFORMATION

Patient Information:

Name_____Birthdate_____
Last First Middle

Address_____ Social Security # _____

City_____State_____Zip Code_____

Female___ Male___ Child___ Married___ Single___ Other_____

Home Phone _____ Cell Phone_____ Email_____

Patient's/Parent's Employer _____Occupation _____

Business Address _____Work Phone_____

City_____State_____Zip Code_____

Spouse/Parent's Name_____ Employer_____ Work Phone_____

Emergency Contact _____Relationship To Patient_____ Phone _____

RESPONSIBLE PARTY:

Name of person responsible for the account and their relationship to the patient_____

Address _____Home Phone _____Cell Phone _____

City _____State _____Zip Code _____Social Security # _____

Employer_____Occupation _____

Employer Address _____Work Phone _____

City _____State _____Zip Code _____

INSURANCE INFORMARION: **(Please present your dental insurance card to receptionist to copy)**

Insurance Company _____ Group# _____

Insurance Address _____

City _____state _____ Zip Code _____

Full Name of Subscriber _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Home Phone _____

Name of Employer_____Work Phone _____

Address of Employer _____ Insurance Phone _____

City_____ State _____ Zip Code _____