



**PAUL A. KLOEK, DDS**  
W7154 Green Valley Road  
Spooner, WI 54801  
Phone 715-635-7888  
[www.greenvalleydentalcare.com](http://www.greenvalleydentalcare.com)

## FINANCIAL POLICY

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Guarantor Initials Page 1: \_\_\_\_\_

### Welcome

Thank you for selecting Green Valley Dental Care as your dental health care provider. We are a committed, compassionate team that is focused on helping you achieve your oral health goals. No matter why you are coming to see us, our team is dedicated to providing you with the gentle, personalized care that you deserve without regard to the limitations imposed by insurance coverage. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

### Payment Options

We deliver the finest care at a reasonable cost to our patients; therefore, payment is expected at the time service is rendered, unless you are informed otherwise. For your convenience we accept cash, personal checks, Visa, MasterCard, Discover and American Express. CareCredit, a patient payment program, is also accepted; to use Care Credit you will need to file a credit application with that company if you are not already enrolled in a Care Credit program.

We offer a 5% courtesy discount for all services that are paid in full on the day of service with cash or check. This only applies if services are paid in full the day the service is rendered. This discount is not to be applied with any other discounts, including our Green Valley Dental Care Savings Plans and traditional dental insurance(s).

A \$45.00 processing fee will be charged for checks returned by the bank for non-sufficient funds (NSF checks). Any penalties assessed on a returned check will be charged to your account in addition to the GVDC NSF fee.

### Dental Savings Plans

Green Valley Dental Care offers several in-house dental savings plans. These plans are designed to provide greater access to excellent dental care at affordable prices for those individuals without traditional dental insurance. This is a discounted fee schedule for most services, not a dental insurance plan. Please see our Dental Savings Plan description, enrollment form, and payment guidelines for details on Savings Plan payment terms.

### Insurance Information

We accept most insurance plans and are contracted with BlueCross/BlueShield, FEP BlueDental, Cigna, Delta Dental, HealthPartners, Humana, MetLife, MetLife Federal Dental Plan, Principal, Tricare, United Concordia, United Health Care, and Security Health/Delta Dental as well as many other insurances. We offer to submit claims even to those companies we are not directly contracted with.

We will work together with you to maximize your insurance reimbursement for covered procedures and, as a courtesy, we will submit the claim for you. Please be prepared to show your insurance card at the time of your visit; this will not only help us file your claim accurately, but will allow us to estimate your coverage with greater reliability. Depending on your insurance carrier, we may be able to submit a pre-treatment *estimate* on your behalf prior to receiving treatment. Pre-treatment estimates are estimates only, but allow you, and us, to have a better idea of the cost associated with your treatment plan. ***Understand that treatment plan estimates are not a guarantee, and you are responsible for all fees generated by your treatment.***



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Please also understand that if you do not provide us with an insurance card at the time of your service, and your insurance information is not pre-verified as active in our system, you will be responsible for the full fee of services rendered until accurate insurance information (including, but not limited to, a copy of your insurance card) the day of service. For emergency exams and procedures, we prioritize your care and comfort and do not always have access to your insurance information prior to treatment. In these instances, understand you will be responsible to pay day or service for services rendered.

**Patient Initials:** \_\_\_\_\_

We will diligently process and provide supporting documentation when required for all insurance claims submitted on your behalf. Although we agree to charge our fees to you based on our contract (or lack of contract) with your insurance company, we are not a party to your insurance contract, and you will be responsible for informing us of any changes to your insurance coverage. Also be aware that if payment is not received from your insurance after 6 months from the day treatment was rendered, the balance will be due in full from you. You will then have to obtain reimbursement directly from your insurance company. Please understand that we cannot accept responsibility for collecting your insurance claim, or for negotiating disputed claims, between you and your insurance company.

**Patient Initials:** \_\_\_\_\_

### **New Patients**

New patients to our practice are expected to make payment at the time of service if this office is unable to verify your plan information before treatment. Any applicable fees or deductibles will be collected, including emergency visit fees. Please complete your new patients forms completely and accurately to expedite the claims process.

### **Patients without Insurance**

All payments for dental services rendered are due at the time of service. Please refer to payment options above and/or talk to our office manager prior to services.

### **Payment After Service**

A statement of your account will be mailed to you each month if an outstanding balance exists. Payment of balance in full is expected upon receipt of statement unless prior arrangements have been made. A finance charge of 1.5% per month (18%APR) will be applied to any balance on accounts 30 days or more past due. The parent or guardian authorizing treatment for a child is the guarantor for those charges and the statement will be sent to the guarantor. The guarantor is not necessarily the insurance subscriber. Should you ever have an account credit please be aware credits \$25 or less must be requested.

### **Patient/Guarantor Signature**

I, (Print your name) \_\_\_\_\_ have read and understand this financial policy. I agree to the terms of this policy. I understand this policy, while it strives to be complete, is not all inclusive.

**Patient/Guarantor Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_