ALCAN
DENTAL GROUP

2819 Dawson Street. Anchorage, AK 99503 Ph: 907-562-4774
Email: info@alcandentalgroup.com

Office Policy and Financial Agreement

For the convenience of our patients, the following office policy and financial agreement has been established for your review.

Cash:
Receive a 5% discount by paying in full with cash at the time of your visit. This discount only applies if you pay in full for all services.

Credit Cards:
We except VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS. We offer these to allow you the most convenience in taking care of your account.

Dental Insurance:
As a service to our patients, we will file your dental insurance via electronic claims. We work with your insurance company to provide the most accurate estimating of your co-pay amount but cannot guarantee any actual out of pocket expense due to the difference in allowed fees by each insurance carrier. PAYMENT IN FULL BEFORE SERVICES ARE RENDERED IS REQUIRED FOR ALL PATIENTS WITHOUT INSURANCE. Insured patients are required to pay the full amount not covered by insurance at the time of the visit. As with all insurances we cannot guarantee coverage and you will be responsible for any amount not covered for your insurance.

Payment Plans:
At this time we do not offer payment plans except with CARE CREDIT/LENDING CLUB. Ask the reception desk about these lines of credit. Regardless of insurance you are expected to pay for all services at the time they are provided.

Cancellations:
As a courtesy to all patients we ask that twenty-four hour notice be given for a cancelled appointment. Multiple last minute cancelled or no show appointments could result in a restriction of the availability for your appointments (only first or last appointment of day) to prevent lost production and to leave availability for emergency patients. **If you miss more than 3 appointments, you will be charged a $100.00 cancellation fee that must be paid in cash BEFORE you will be allowed to reschedule.**

Patients Printed name or Legal Guardian name: _____

Patients Signature or Legal Guardian of a Minor: _____

Date: _____

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Use of Dental Insurance and Payment Agreement

We are committed to providing you with the best possible care. If you have dental insurance, we will bill your primary and secondary plans. We do not file a third insurance company.

Your co-payment and deductible are due on the day the services are rendered. We accept cash, checks, Visa, Mastercard, Discover, American Express, and Care Credit/Lending Club.

If you do not have insurance, your payment is due the day the services are rendered.

Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. Our relationship is with you, not with your insurance company.

Please sign below:

- I understand that the filling of insurance claims is a courtesy extended to me and that all charges are my responsibility from the date the services are rendered.
- I understand that the insurance verification percentages and annual maximum amount given to the staff at Alcan Dental Group by my insurance company is not a guarantee of payment by my insurance company.
- I also understand that my insurance may not pay for all services as stated. After I have paid the co-pay requirement, and the insurance company has paid Dr. Laudon/Alcan Dental Group, I am aware that I will receive a bill for the remaining unpaid balance.

Patients Printed name or Legal Guardian name: _____

Patients Signature or Legal Guardian of a Minor: _____

Date: _____