AlmondDental
Comprehensive, compassionate care.

11301 Fountains Drive Maple Grove, MN 55369, 763.762.7177
3803 Silver Lake Road, St. Anthony, MN 55421, 612-782-7000

Policy and Patient Responsibility

Thank you for choosing Almond Dental as your dental care provider. We are committed to your treatment being successful. Please understand that prompt payment of your bill is considered part of your treatment. We have put together the details of our credit and financial policies below. Please read carefully and sign below before you begin treatment. All patients must complete our information and insurance forms.

FULL PAYMENT IS DUE AT THE TIME OF SERVCE.

For your convenience we accept cash, Personal Checks or Visa, American Express and Master Card.

We offer payment plans with Care Credit with prior approval and signed agreement.

A finance charge of 18% annually (1.5% per month) will begin accruing 60 days after the date of service.

PATIENTS WITH INSURANCE COVERAGE

We will accept assignment of insurance benefits. However, we do require your co-payment to be paid at the time of service. The balance incurred is your personal responsibility whether your insurance company covers it or not. Coverage amounts vary from policy to policy and we cannot guarantee the amount of coverage offered by your insurance carrier. It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. You understand that you insurance policy is a contract between you and the insurance company. Our office will not be held responsible in the event your insurance company denies any claim.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for your payments regardless of what your insurance company covers.

DELINQUENCY

In the event your account becomes past due and is referred to an outside collection agency or attorneys, you will be responsible for the collection cost up to 33% of the balance due. Along with reasonable attorney fees and court cost incurred by this office.

I have read and understand Almond Dental credit and financial policy with respect to payment on my account.

Signature: ____

Date ______________________ Name (Print) ______________________________

HIPAA

☐I certify that I have read and understood the HIPAA Notice of Privacy Document.

Signature: ______________________________________ DATE: ______________