Joseph A. Petrino DDS, MS
Diplomate, American Board of Endodontics
705 S. Reserve Missoula, MT 59801
Office #: 406-542-1600

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment success. Please understand that payment of your bill is considered part of your treatment**.**

Payment is due at the time services are rendered.

For your convenience, we accept:
Cash and Checks: A 10% discount is offered for full payment on the day of service with cash or check.
Cherry: Application assistance is available at the front desk.
CareCredit: 6 or 12 months no interest programs or 24 months at 17.9%
Discover, Visa, Mastercard, and American Express.

Please inform the front office as to what form of payment you will be using.

For patients with insurance coverage:
A 40% deposit will be collected at your treatment appointment. We may accept insurance benefits for your treatment. However, we do require 40% of the cost of treatment to be paid at the time of service.
The balance is your responsibility, whether your insurance company pays or not. As a courtesy, we will be happy to file your claim for you if you present your dental insurance card. We cannot bill your primary insurance company unless you give us your complete insurance information on your initial visit. Our practice is committed to providing the best treatment for our patients, and we charge for what is usual and customary for our area.

> **We do not bill any secondary insurance. We can provide you with all the necessary documentation to be submitted by you.**
>
> **We will not pre-verify your insurance coverage or your specific plan's benefits before providing treatment.**

If you fail to provide your accurate insurance information when receiving treatment, you will be responsible for paying in full and submitting a claim to your insurance company, acting as your own billing agent to get reimbursement from your insurance company.

Your insurance policy is a contract between you and your insurance company.
We are not a party to that contract.
We are not a network provider for all insurance plans.
The insurance company's verification of coverage does not guarantee payment.

If your insurance pays MORE than the estimated amount, a refund check will be mailed.
If your insurance pays LESS than the estimated amount, you will receive a billing statement from this office. We usually do not send monthly statements, so prompt attention is greatly appreciated!

(Note: If your insurance company does not reimburse us after 2 submissions, you will be responsible for the remainder of the balance.)

Finance Charges:

If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. It is the patient's responsibility to know, understand, and track their insurance benefits, deductibles, and maximums.

Financial Responsibility Agreement

If I do not pay the full balance within 60 days of the original billing date, a finance charge will be assessed on the account. This finance charge is calculated at a periodic rate of **1.25% per month** (an **annual percentage rate of 15%**) on any unpaid balance over 60 days.
Any account with an outstanding balance over 60 days will be considered for referral to a **collection agency**. **Civil penalties may apply.** In the event of default on payment, I agree to pay any applicable **legal interest on the unpaid balance**, as well as **all costs and fees incurred**, including third-party collection agency fees, legal fees, and any other expenses necessary to collect on this or future delinquent accounts.
A **$30 fee will be charged for all returned checks**.

COLLECTIONS

Accounts in Collection

Any account that has not been paid in full within **60 days** of the original billing date will be referred to a **collection agency** for recovery of the balance.

Collection Agency Fee

If your account is referred to a collection agency, an **additional fee of 16% of the total balance due** will be added. This fee covers the costs associated with the services provided by the collection agency.
Referral to collections may **negatively impact your credit history** and may also **limit the treatment we can provide to you in the future**.
Thank you for your understanding and cooperation with our financial policy. If you have any questions or concerns, please do not hesitate to reach out. We are dedicated to delivering the **highest quality endodontic care in a compassionate and professional environment**.

I have **carefully read and understand** the Financial Policy provided to me. I acknowledge and agree to comply with this policy for **all appointments at this office**.
I confirm that I have had the opportunity to ask any questions regarding this policy and have received satisfactory answers. I hereby authorize the release of any information necessary to process claims for benefits on behalf of myself, my spouse, or my dependents. I also authorize the **assignment of insurance benefits directly to this office** for services rendered.

Signature: _____ **Date:** _____