Pine Desert Dental
(541) 549-0109
304 W Adams Ave
Sisters, Oregon
977592619
USA
info@pinedesertdental.com

Aug 23, 2024

Pine Desert Dental Financial Responsibility

K. Zachary Sunitsch, DMD, LLC
Financial Responsibility Policy

Our Financial Responsibility Policy is a necessary part of assuring the financial resources needed to maintain quality dental services for our patients. Our goal is to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies. Please do not hesitate to ask about the cost of a procedure before it is performed- we are happy to discuss this with you.

We request full payment at the time of service if insurance does not cover your visit. If we are billing your insurance carrier, you will be expected to pay your deductible and estimated co-payment. We accept cash, check, all major credit cards, as well as Care Credit for payment.

Insurance: We will, as a courtesy to you, bill your insurance. This is done with the understanding that you remain totally responsible for your charges, regardless of your insurance coverage. We will look to you for payment if your insurance has not paid within 60 days of service. We do not have control over your insurance company's interpretation of their responsibility to pay your bill, or agreement is with you.

Appointment Policy: We require 48 office business hours notice for any schedule changes. If adequate notice is not given, you will be charged $50 per ½ hour scheduled. If you miss an appointment without proper notice, we reserve the right to charge you for said appointment, and no longer schedule you with our practice. This policy is up to the discretion of Dr. Sunitsch and staff.

By signing below, I personally guarantee and accept responsibility for all charges incurred by me or my dependents- regardless of any insurance coverage I may or may not have.

Accounts that are over 90 days old are subject to a 1.75% monthly service charge (21% APR). Accounts referred to a collection agency are subject to collection and attorney fees. There is a $25 fee for all returned checks.

We appreciate the opportunity to serve your needs!

First name - Patient

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Last name - Patient

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Signature

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