prairie ridge ENDODONTICS
810 S Maple St, Watertown, SD 57201 Fax (605) 878-0180
701 N 4th St #100, Aberdeen, SD 57401 Fax (605) 226-2790
Tel: (605) 878-0180 Web: PrairieRidgeEndo.com

Financial policy

- Payment in full for services is to be made at the time of treatment.
- We accept cash, personal checks, Carecredit, Visa and Mastercard.
- As a courtesy to our patients, we can contact your insurance company by request to get an estimate of coverage. This is an estimate and not a guarantee of payment on the insurance company's part. The patient has a right and a responsibility to be aware of his or her insurance coverage, independent of our office's inquiries. As a patient, it is in your best interest to know and understand your insurance policy and coverage. Not all services are covered in all insurance contracts.
- We must emphasize that as health care providers, our relationship is with you, not your insurance company. We are participating providers with Delta Dental. While we are not participating providers with other insurance companies, we will be happy to file your insurance claim, provided you have given us your current insurance information. We will charge you based on the estimate received from your insurance company, if any. For your information, final determination of insurance payment is made when they receive the claim. If they do not pay us as much as anticipated, we will bill you for the remainder. If they pay more, we will issue a refund.
- For those who are interested, we offer a payment plan through Carecredit. For more information, visit carecredit.com, or call our office.
- For patients being treated by apicoectomy, there will be a separate lab fee charged to you or to your medical insurance by the University of Minnesota Oral Pathology Laboratory. It is the patient's responsibility to contact his or her insurance company to find out if the lab service is covered. If you need assistance, please call our office.
- If there is an outstanding balance on your account, please understand our office reserves the right to not schedule any subsequent appointments until the amount is paid in full.

I have read and I understand the Prairie Ridge Endodontics' financial policies and agree to abide by their contents.

Signature of parent or guardian: _____

Date: _____