value dental

1212 N. Cole Rd.
Boise, ID 83704
(208) 375-4253

APPOINTMENTS
We will do our best to schedule your appointment at a convenient time. Twenty-four hour notice is requested if you are unable to keep your scheduled appointment. Appointments are confirmed by phone whenever possible. If we are unable to reach you, we trust that you will keep your appointment or a cancellation fee may be charged.

INSURANCE
We must emphasize that our relationship is with you, not your insurance company. We file the claim as a courtesy to our patients, but all charges are your responsibility from the date the services are rendered. All insurance estimates are exactly that – only an estimate. Not every service is a covered benefit in all contracts. The insurance companies have their own fee schedules and they make their payments based on that. There may also be waiting periods and time limitations placed on certain services. It is important that you read and understand your dental insurance policy and its requirements for coverage. We currently send claims to over 1000 plans and are not responsible for knowing the requirements of your specific plan. All deductibles and co-payments are due at time of service.

FINANCIAL
Payments are due at the time treatment is provided. We accept cash, checks, Visa, MasterCard, Discover and American Express. We also offer Care Credit, Lending Club, and Prosper if you need to make payments. Any balance older than 90 days is subject to a billing charge of $5.00 per month or finance charges of 18.0% A.P.R.

PAST DUE BALANCES
A past due balance is any amount owing from a prior visit, where insurance is not pending or an insurance payment has not been received by us within 90 days. If you have a past due balance and wish to received service, you will be required to pay the past due balance and the new charges at the time of service.

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance on my account for any professional services received. I have read the above information and agree to the above stated policy, and have received a copy of said policy.

Signature of Patient or Responsible Party

Date