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**Las Vegas Dentistry, LLC**  
**2421 W. Charleston Blvd. Las Vegas, NV. 89102**  
**dentistoflasvegas.com 702-870-3818**

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### FINANCIAL POLICY

Las Vegas Dentistry, LLC is glad to have the opportunity to serve you. Please read and sign our Financial Policy and Assignment of Benefits agreement. Should you have any questions, please let us know.

Full payment is due on the day and at the time the service is provided. Any additional fees incurred (See Appointment Policy, Assignment of Benefits, etc.), if any, must be paid within 60 days. Our office accepts most dental insurances, all major credit cards, cash, and personal checks. In addition, third party financing is available upon request with approved credit. There is a \$25 fee for dishonored checks.

Dental Insurance Patients: As a courtesy and for your convenience, on the day the service is provided, our team will submit your claim to your insurer on your behalf. In order for us to do so, you must sign the "Assignment of Benefits" agreement below authorizing us to deal directly with your insurer. You will also need to provide proof of your insurance and complete the Patient Registration form with your dental insurance information. We will also collect your estimated patient portion at this time.

The patient is ultimately responsible for all the incurred charges, regardless of insurance coverage. Although we do our best to interact with insurance companies, our office is not a party to your insurance contract and we cannot know all the possible restrictions or limitations of your agreement with your insurer. We must emphasize that as your dental care provider, our relationship is with you, our patient, and not with your insurance company, so we are limited to the information you and your insurer provide to us.

Balances over 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

### ASSIGNMENT OF BENEFITS

I hereby assign my insurance benefits from my insurance company to Las Vegas Dentistry LLC for the treatment received. I understand that the contract regarding my benefits is between me, the patient, and my insurance company. I agree that the financial obligation to pay for the treatment received and any other fees incurred is mine, regardless of the amount that may or may not be reimbursed by my insurance company.

The following provisions govern:

- Although Las Vegas Dentistry may assist me in completing insurance forms and submit my claim on my behalf, Las Vegas Dentistry is not responsible for the outcome of the transaction. Completing insurance forms is a courtesy extended to me, in an effort simplify the insurance claim process and to maximize my insurance reimbursement. In having Las Vegas Dentistry process my insurance forms, I understand that this does not eliminate my financial obligation for the treatment I or my dependent have received.
- By signing, I instruct my insurance company to make payments directly to Las Vegas Dentistry LLC.
- I will pay my estimated patient portion, which is the amount not covered by my insurance company, at the time service is provided. I will also pay any other balance outstanding that my insurance does not cover.
- I or my employer may have negotiated an insurance plan, which pays less for certain procedures. I acknowledge that I am responsible for any amount not covered, and as this information is not usually given out to non-signers of a contract, it is my responsibility to contact my insurance company for clarification.

I \_\_\_\_\_ (Print name) have read and accept the Financial Policy and the Assignment of Benefits conditions. I hereby authorize my insurance company to pay my insurance benefits directly to Las Vegas Dentistry LLC.

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date