



NORTHSTAR DENTAL

SARAH CARLSON DDS

675 E Nicollet Blvd, Ste 120
Burnsville, MN 55379
952-892-7700

PATIENT PAYMENT/ CANCELLATION POLICY

Thank you for choosing our office! We are committed to providing you with high quality and affordable dental care. Our fees are representative of the usual and customary charges for our area. Please understand that prompt payment of your bill is part of your treatment and care. We proudly offer the following financial policy so that you have the opportunity to decide which payment option best suits your needs.

Dental Insurance:

As a convenience to you our office will be happy to submit claims to your insurance company. Recommended treatment is determined by what is best for your dental health and not based on your insurance coverage. Your insurance company may or may not cover all recommended procedures. *We request that you understand your insurance policy in advance so that together we can make the best treatment decisions.* Please remember that dental insurance is not designed to cover 100% of the cost of your treatment. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Payment Options:

- Pay in full with cash or check at the end of the appointment and receive a 5% prompt payment reward.
- Pay in full at time of service with Visa, Discover, MasterCard, American Express, or Care Credit.
- For patients with insurance your estimated portion is due at time of service.

Nonpayment/ Delinquency:

A finance charge of 18% annually (1.5% per month) will begin accruing after 45 days from the date of service. If your account is 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Please be aware that if a balance remains unpaid your account will be referred to an outside collection agency or attorney, YOU will be responsible for the collection costs (up to 33% of the balance due,) along with reasonable attorney fees and court costs incurred by our office.

Cancellations:

Please understand that our appointment times are scheduled to allow us to take care of each individual's needs during the patient's visits. Since appointment times at our office are in high demand, we value advanced notice from our patients who are unable to keep their scheduled appointments. In an effort to decrease unnecessary costs related to staffing and supplies, we maintain a No-Show/ Cancellation policy for all of our patients. **We require that you give our office at least a 24-business hour notice** if you need to reschedule your appointment. Cancellations must be done over the phone by speaking directly to one of our dental professionals. This allows for other patients to be scheduled into that appointment. In the event an appointment is missed or cancelled without contacting our office within the required time, a fee of \$50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee. If three no-show or same day cancellations occur, in a 12-month period, we reserve the right to terminate the doctor-patient relationship. This policy is in effect for all appointments at our office. Please acknowledge that you have had the opportunity to review this policy by signing below.

I, the undersigned, hereby authorize the release of any information relating to all claims for benefit submitted on behalf of myself, spouse, or dependents including the assignment of benefits payable to Sarah L Carlson DDS PA. I also acknowledge and understand that if the account is turned over to an attorney for collection, I hereby agree to pay thirty-three percent (33%) attorney or collection agency fees on the unpaid balance. I also have read and understand the payment/ cancellation policy and agree to abide by its guidelines.

Print Patient Name

Signature of patient or responsible party

Today's Date