Financial Policy

Thank you for choosing Clock Tower Family Dental for your dental care needs. The following information will explain our procedures and policies, which have been established so that we may serve you as promptly and efficiently as possible. Financial arrangements must be made prior to treatment.

- Payment is due in full at the time of service for patients without dental insurance. Patients with insurance coverage are responsible for any deductible and estimated co-payments at the time of service.
- Third party financing is available for patients requiring extensive treatment ($300 or more with approved credit). See our Treatment Coordinator for more details on the Care Credit program.
- In the event you would like to pay up front at the time of service in cash/guaranteed funds, we would not process a credit inquiry. However when we bill insurance and accept assignment of future insurance and patient payments, we do reserve the right to run a brief credit inquiry in order to establish a history with the patient. With or without insurance we do reserve the right to run a credit inquiry.

A Word About Dental Insurance

As a service to our patients we will bill your insurance company. However, your insurance policy is a contract between you and your insurance company. Insurance policies vary and services provided may not be covered. You are responsible for any fees insurance does not pay. For example, Clock Tower Family Dental is not contracted with any insurance company except Delta Dental of Colorado Premier. Every insurance has different usual and customary fees that they pay, and when insurance says the pay 100% of cleanings, etc., it does not mean that 100% of our fee will be paid. The remaining balance is the responsibility of the patient. Recently we have noticed that patients with dual coverage, in some cases, the secondary insurance company will not pick up any or all of the remaining balance. Please refer to your employee manual for specific coverage explanations. If your insurance has not paid within 60 days we ask you to clear the balance within 15 days.

If you have any questions regarding treatment, fees or services, please feel free to discuss them with us at any time. Provisions and policies contained in this agreement may change at any time and without prior written notice.

I understand and agree to abide by the Financial Policy.

Signature of
Patient/Responsible Party ____________________ Date ____________