

**William W. Calhoun, D.D.S.**  
**7800 Ustick Road**  
**Boise, Idaho 83704**  
**(208) 322-0040**

**INSURANCE COVERAGE**

Coverage by insurance or third party carriers is solely the responsibility of the insured. As a courtesy to you we will complete an insurance form to be supplied to your carrier detailing your treatment. To avoid misunderstanding with regard to your benefits, we suggest you review your policy manual. Patients will be financially responsible for all treatment rendered. Within reason, we will assist you in obtaining reimbursement from your carrier as long as current information is provided.

**PAYMENT POLICY**

Payment is due at the time of service. Please note, not all services may be covered by your insurance carrier and every insurance plan has its own unique "quirks" and exceptions. It is the patient's responsibility to cover procedures that are not covered by their insurance plan.

**FINANCE CHARGE**

A FINANCE CHARGE OF 1 3/4% per month (21% annual percentage rate) will be applied to account balances overdue 60 days, \$.50 MINIMUM CHARGE.

**CANCELLATION POLICY**

There are many times that our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give us advance notice of their need to cancel a scheduled appointment, this time can then in turn be given to these patients in urgent need of treatment. In this way, we can best serve the needs of ALL of our patients.

Bearing these special needs in mind, we require a minimum of 24 hours notice if an appointment must be cancelled. If less than 24 hours notice is given to cancel an appointment, a \$75.00 fee\* will be assessed. Please note this fee is not covered by dental insurance and payment is the patient's responsibility.

\*Exceptions will be made for illness or personal tragedy.

We look forward to taking care of your oral health needs and welcome you and your family to our team of dental professionals.

I have read the above policies and understand my responsibilities as a patient.

**INSURANCE INFORMATION**—Please fill in completely if you have dental coverage:

Name of insurance carrier \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Employee \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Patient's Relationship to Employee \_\_\_\_\_

Secondary (other) Insurance Information: Is the patient covered by another plan? \_\_\_\_\_

Name of insurance carrier \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Employee \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Patient's Relationship to Employee \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_