Financial, Scheduling & Communication Agreement

Financial Agreement

At Big Sky Dental Center, we believe in providing high-quality dental care and strive to recommend the best possible treatment for each patient. We also understand that financial considerations may influence your treatment decisions. Our team is committed to helping make dental care more accessible by offering flexible payment options, including third-party financing.

We work with most dental insurance companies and make every effort to help you maximize your available benefits through accurate documentation, claim submission, and communication with your insurance provider. We are an out-of-network provider and do not participate in insurance networks. However, we will submit claims to your insurance company on your behalf and are happy to assist with questions regarding your claims.

Please understand that we work for our patients, not the insurance companies. We believe dental insurance can be a valuable benefit, and we will do our best to help you receive the benefits available under your individual insurance plan. However, our treatment recommendations and fees are based on your individual dental needs, not on your insurance coverage.

Payment for treatment is due in full at the time of service. Your insurance company may reimburse you directly according to the terms of your policy. As a dental practice, we must maintain our own financial responsibilities and appreciate your understanding.

We accept all major credit cards. Patients who qualify may also take advantage of deferred-interest or fixed-payment financing options through third-party providers, such as CareCredit. Please ask our team if you would like additional information about available payment options.

Scheduling Agreement

We value your time and strive to maintain an on-time schedule. We also understand that delays can occasionally occur. In the rare event that we are running behind for your appointment, we appreciate your patience and will make every effort to keep you informed.

As a courtesy to our patients, the following will be offered based on the length of an office-caused delay:

- **5-minute delay:** $5 gift card

- **15-minute delay:** $25 gift card
- **30-minute delay:** $100 credit toward treatment

We require confirmation for all scheduled appointments. For your convenience, we offer an electronic patient communication system that may include email correspondence, text messaging, and patient satisfaction surveys.

You may opt out of electronic communications at any time by using the unsubscribe instructions provided in an applicable automated message or by contacting our office at **406-586-5949**.

Appointment Guidelines

We will send appointment reminders and confirmation requests by text message and/or email when applicable. Please remember that **at least two business days' notice is required to cancel or reschedule an appointment.**

Text and email reminders are provided for your convenience; however, **cancellations and rescheduling requests must be made by calling our office directly.** Please do not rely on a text or email response to change or cancel your appointment.

Your reserved appointment time is set aside specifically for you. Late cancellations and missed appointments limit our ability to accommodate other patients and may delay your own dental care.

A **$100 fee may be assessed for appointments cancelled with less than two business days' notice or for missed appointments.** If an emergency or unforeseen circumstance makes a change unavoidable, we will review the situation and may adjust the fee at our discretion.

Two or more late cancellations or missed appointments may result in a requirement for prepayment to reserve future appointments or dismissal from our practice.

We appreciate your cooperation and understanding as we work to provide timely, high-quality care for all our patients.

Patient Acknowledgment

I have read and understand the Financial, Scheduling, and Communication Agreement outlined above. I understand my financial responsibilities, the office's appointment policies, and my options regarding electronic communications.

Patient Name (Print): _____

Date: _____

Patient Signature: _____