Financial Agreement and Consent for Services

In an effort to keep dental costs down while maintaining a high level of professional care, we have established the following payment plans for the benefit of our patients. Fees may be paid as follows:

1. We ask that payment for services rendered be **paid at the time of service**. If you have insurance we will *estimate your portion* based on any previous experience we have had with that carrier. Please pay this at the time of service. We will bill your insurance company for the charges and send you a bill for any remaining balance that is not covered. If your insurance reimburses our bill directly to you, the subscriber, we ask that you pay our fees in full on the day of service. As a courtesy, we will submit a claim to the insurance company for you.

2. If you have insurance, please remember that the insurance is a contract between you, the subscriber, and your insurance company. Many insurance companies pay based on a "Usual & Customary fee". In some cases our fees may be higher than your insurance company's Usual & Customary (UCR) fee.

3. Accounts outstanding more than 60 days from the date of service will accrue interest at 2% per month or 24% annually.

4. Treatment involving a laboratory procedure will require payment at the time the impression is taken.

5. The age of majority in the state of Washington is 18 years old. Parents bringing minor children to us for their appointments will be responsible for payment. If another parent has financial responsibility for the child, we will ask that the parent bringing the child remit payment at the time of the appointment. We will be glad to provide you a receipt.

6. For your convenience we accept Visa and MasterCard.

7. Past due accounts will be sent to a collection agency at our discretion. There will be a $35 fee added to the account once it is referred to collection. A charge of $25 will be assessed to your account should a check be returned due to insufficient funds.

8. **Our office reserves the right to assess a $100.00 broken appointment fee. We request, at a minimum, 2 working days notice should you need to reschedule your child's appointment.**

9. We do not accept post-dated checks.

I agree that I am responsible financially for all balances due.

I have read the above conditions of treatment and payment and agree to their content. I grant my permission to you or your assignee to telephone me at home or at work to discuss matters related to this form.

_____Date:_____Relationship to Patient: _____

Signature of Parent or Legal Guardian

_____Date:_____Relationship to Patient: _____

Signature of Parent/Legal Guardian Responsible for Payment

SIGNATURE REQUIRED ON BOTH LINES