

OFFICE FINANCIAL POLICY

*I*n our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment.

Please check your preferred option below:

- 5% Accounting Courtesy for payment in full with cash or check at time of service
- Visa or MasterCard
- Payment or Layaway Plan

*W*e are committed to support you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solution possible to treat your personal situation.

*A*s a courtesy, we will process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that **any estimated portion, not covered by insurance, is due at time of service** for all services rendered. I understand that all services are due to be paid within ninety (90) days of date of service, regardless of whether or not my insurance benefits have been received. One percent (1%) per month interest, twelve percent (12%) per year (per RCW 19.52) will be charged on accounts 90 days from treatment date. I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data.

*W*e are here to assist you in any way possible. Please make your questions and concerns known to our team ... Our goal is to ensure that you have an outstanding experience.

Signature (responsible party)

Date