Financial Policy

Federal Way General & Laser Dentistry has worked provides a variety of payment options to help you receive the dental care you need and deserve to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

Payment Terms:

1. **Payment Due at Time of Service:** Any single visit treatment, fee estimates are due at the time of service unless other arrangements are made prior to your appointment**.**
2. **Major Service - Two Payment Option**: We offer payments for treatment that requires multiple visits. We ask that you pay one-half of your co-payment at the first appointment and the second half at the seat date appointment.
3. **Term Loan**: By arrangement with Care Credit or other outside financing, we offer term loans. Please inquire within.

Appointment times are reserved exclusively for you. Courtesy of advance notice when you are unable to keep an appointment is appreciated and required. We reserve the right to charge and collect fees of **$75.00 per scheduled hour** for appointments that are missed or canceled without 48 hours business-notice (Office Hours M-Thurs 9am-5pm, Fri 10-2). Cancellations with less than 48 hours-notice are considered missed appointments. Patients who miss an appointment may be required to have a credit card on file or pre-pay for treatment. Missed appointment fees accrued may be deducted from deposits or pre-paid treatment already paid. Initial_____

Returned Checks: There will be a $35.00 NSF handling charge for any returned checks.

Handling of Account & Statements: Statements are sent monthly by our office to accounts with remaining balances after insurance settlement. Unpaid balances accrue interest at 1.5% per month (18% APR) in addition to a statement fee of $2.50 after 30 days or the initial statement. Statement charges apply immediately when patient leaves without paying estimated fees for their visit. Any account not paid by the 3rd statement may be referred to our collection attorney. Initial _____

I have read the Financial Policy and I understand and agree to this Financial Policy for myself & members on my account:

Signature of Patient or Responsible Party: _____ Date: _____

Name Printed: _____

FOR INSURED PATIENTS:

Insurance benefits are not a guarantee of payment and may not cover all costs. Insurance policies are a contract between you and your insurance company. Patients/Guardians are responsible for their account and for services not covered by the plan. Filing of claims is a courtesy that we extend to our patients and we will do our best to maximize the benefits that you are legally entitled to. Our office carefully provides estimates for treatment based on information & fees provided by your insurance company. Estimated payments should be considered a guideline until the final insurance payment is received and posted to your account. Our fees may not correspond with those of your insurance company. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **Our office CANNOT GUARANTEE the insurance payment as estimated.** Should additional problems arise as treatment progresses, treatment plan fee estimates may be revised. The patient will be informed of any increased fees and/or additional recommended treatment. Initial _____

We reserve the right to bill the account holder directly for any payment not made by your insurance company within 90 days. We will make every reasonable effort to get your claims paid and/or assist you with any questions or concerns you may have regarding your account. Our office is highly successful in resolving most unpaid insurance claims & disputes with dental insurance companies, however, we will not be held responsible for collecting an overdue insurance claim or for negotiating a disputed claim beyond reasonable effort. Initial _____

ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist's use of My Images anonymously in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent of the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. For patients who are minors listed on account and are unable to pay his/her Uninsured Costs, the undersigned agrees to guaranty the payment of such Uninsured Costs to the Patient's dentist in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risk and limitations involved with the dental treatment I am to receive.

Signature Pt/Guardian _____ **Date** _____