

## ***Financial Policy***

***We thank you for choosing us as your dental provider. We are committed to providing exemplary dental care to all our patients. Please understand that your bill and payment is also considered part of your treatment.***

***Understand that any balance from treatment is your responsibility whether your insurance pays or not. You are liable for any and all procedures that are not paid by your insurance due to frequency limits (procedures done too soon that we already paid for by your insurance to another provider for the same tooth), and or other specifications detailed in your insurance handbook or lack of coverage. Your benefits are your responsibility to know, you may want to ask for a benefits packet from your insurance and take a moment to become familiar with your specific plan. All co-pays and deductibles are due at time of service unless other arrangements have been made prior to treatment. Any balance over 90 days is due in full immediately or other action will be taken. Failure to keep a financial agreement will result in loss of payment agreements for future services. We accept most major credit cards, checks and cash. Financing is an option through Care Credit (O.A.C.). As a courtesy to our patients, we will happily bill your insurance for you, providing that you keep us current on your coverage. Your insurance policy is between you, your employer and your insurance. Most delays are resolved with a simple call from the patient to their insurance, or help from their HR department. If your account is not paid within 90 days (excluding dual insurance), the balance becomes your responsibility in full. If your account is referred out for collections, the venue will be in Grant County Washington. Our front office will be able to answer questions regarding what insurances we bill and what financial arrangements may be available to ensure that our patients have access to desired treatment.***

***We ask that in the best interest of all our patients, that if you cannot keep a scheduled appointment, that you notify us 24 hours in advance.***

***Thank you for understanding our policy, and for giving us the opportunity to be the best dental team to all our patients.***

***Signature*** \_\_\_\_\_

***Date*** \_\_\_\_\_