Premier Dental Clinic
3825 Martin Way E #101
Olympia, WA 98506

Office Policy & Financial Agreement Options

Initial

_____ Payment in full or validated insurance coverage along with estimated co-payment is due at the time of service. For our patients who are not covered on any type of dental plan, our office offers a discount of 5% as a courtesy if payment is made in cash or check. Our office accepts cash, check, debit cards, Visa, Mastercard, or Discover card.

_____ Arrangements for payment other than in full must be made prior to appointments.

_____ We are happy to bill your insurance company. Insurance companies do not guarantee eligibility or amounts covered until claims have been received and reviewed, thus co-payments may actually be different than those quoted.

_____ If an insurance company fails to pay any outstanding balance, then payment in full is the responsibility of the patient or person responsible for the account.

_____ Balances over 30 days past due are subject to a finance charge of **18%APR**. Any accounts over 60 days past due may be forwarded to an outside collection agency for payment. Any collection or attorney fees are the sole responsibility of the patient or person responsible for the account.

_____ We must have a completed patient information sheet on every patient. If your address, employment, or insurance has changed since your last visit, please inform our receptionist so we may update your file.

_____ Every patient is important to us. We will endeavor to make arrangements suitable to you in every case. We ask only that you help us by letting us know in advance if you need special arrangements.

_____ Returned checks are subject to a **$35.00** charge.

_____ We ask that 24 hours (business office hours) be given for any cancellation of appointments so that we may fill in that time with someone else who may desire to have treatment. Cancellations **without 24 hours notice** or a **No Show** will result in a **$45.00*** charge. *(some plans may have agreed upon cancellation fees)

Informed consent disclosure, assignment and release of information:

If I consent and elect to proceed with treatment, I hereby authorize my insurance benefits to be paid directly to the dentist and understand that I am financially responsible for services not insured. I further authorize the dentist to release any medical or dental information or other records, including x-rays, necessary in the conduct and disposition of my case.

_____ _____
Signature of patient or legal guardian Date

_____ _____
Witness Date