7471 SW Barbur Blvd
Portland, OR 97219
(503) 246-8447

FINANCIAL AGREEMENT

Taking care of you and your family is our highest priority. That is why, when it comes to talking about finances, our goal is to provide you with clear information regarding our dental fees and discussing payment options. All patient portions and deductibles are due at the time of service. We will provide you with an estimate of the total fees expected. Please understand that this will ***ONLY*** be an estimate. Treatment needs can change for a variety of unforeseen reasons. Whenever possible, we will inform you of any treatment changes that will affect your financial estimate.

When estimating insurance coverage, we must also stress the word ***estimate*** as dental benefits are determined by each patientøs dental contract. Most dental plans are designed to ***assist*** patients with their dental expenses. Very few dental plans fully cover all dental services. If you provide us with a copy of your dental plan, our staff will be happy to help you interpret your dental benefits. Without a copy of your benefit plan, only an estimate can be provided based on what a õtypicalö plan provides. If your dental plan pays more than expected, you will receive a prompt refund. If your dental plan pays less than expected, a balance due will be reflected on your monthly statement. If your dental plan later determines that you were not eligible for coverage, the balance becomes ***YOUR*** responsibility.

- As a courtesy, we bill your insurance on your behalf. Any questions regarding coverage, non-payment, benefit or /payments different than expected, is **your** responsibility. Please contact your dental insurance company with any questions you may have as your dental policy is a contract between you and them and is not the responsibility of the practice.
- A twenty four (24) hour notice is required to cancel an appointment. If unable to give twenty four (24) hour notice, a minimum of $100.00 doctor cancellation fee and a minimum of $75.00 hygiene cancellation fee will be applied.
- All ***NO SHOW*** appointments will be billed a minimum $100.00 doctor fee and a minimum of $75.00 hygiene fee.
- After three (3) no show appointments, you will be charged for the ***FULL*** value of the scheduled appointment missed.
- Finance charges of 1.8% per month will be assessed on balances over 60 days with a minimum of $1.00 per month. In addition, balances over 90 days will also be assessed a $10.00 billing charge per month.
- In the event of non-payment, I hereby agree to pay all courts cost, collection fees and attorneyøs fee.
- I hereby authorize payment directly to the named dentist.

I have read the above and understand this financial agreement.

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Print Name

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Signature Date