



# Tenino Family Dental

## Financial Policy

It is our policy to receive payment in full for dental treatment at the time of service. We realize that each person's financial situation is different. For this reason we provide the following options to help you receive the dental care needed to enjoy a healthy and confident smile.

## Dental Insurance

We are happy to file the necessary forms to see that you receive the full benefits of your coverage; however, we make no guarantee of any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we consider all patients responsible directly for all charges. Your estimated portion is due at the time of service. We can take no responsibility for plan benefit maximums, denied coverage or required co-payments. If for some reason your insurance company has not paid their portion within 30 days from the date of service, you are responsible for the balance at that time. In addition, a 1.5% charge will automatically be added monthly on any remaining balance until paid in full

## Uninsured

We request payment in full at the time of service, payable by cash, check, or major credit card. We also have applications on hand for a dental line of credit that offers interest-free options. We offer our uninsured patients a 5% discount for cash or check when paying at the time of service.

## Payment Options

Cash or Check: We offer our uninsured patients a 5% cash courtesy for payment when paying by cash or check at time of service.

- Credit Cards: We gladly accept payment by most credit cards.
- Health Care Credit Card: Interest free options available on approval of credit.

## Cancellation / Broken Appointment Policy

We take the time we dedicate to your appointment very seriously. We expect the courtesy of a cancellation of appointments with 48 hours notice. We reserve the option of charging a \$50 service fee for appointments cancelled or broken without adequate notice, generally 48hrs.

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An estimate of the charge for any procedure you may require will be given to you when diagnosed. If you have any dental insurance we will be glad to fill out the proper forms, but please give complete information on this form.

**It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.**

I have read and understand the above financial policy. I am responsible for payment of all fees for myself and/or my dependents. I authorize Tenino Family Dental Center to furnish information to insurance carriers concerning my or my dependent's treatment. I hereby assign all payments for dental services rendered to Tenino Family Dental Center.

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Signature of patient (Parent or Guardian if Minor)

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Date

This Signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

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Signature of patient (Parent or Guardian if Minor)

Date