

KIRKLAND DENTAL
FINANCIAL POLICY

INSURANCE: As a courtesy to our patients, we will submit insurance claims directly to your insurance carrier. We can estimate and will assist you in determining your insurance benefits. Any uninsured portion is due at the time of service. If for any reason, the estimated amount is not paid by your insurance company, you will be responsible for the unpaid balance.

We encourage you to overview your policy in detail so that you are aware of your plan specifics and maximum coverage.

NON-INSURED SERVICES and EMERGENCY SERVICES: Payment in full is required at time of service.

We fully believe dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we do provide a number of payment options.

PAYMENT OPTIONS

Please check the box that applies to you.

Payment in Full - A bookkeeping courtesy of 5% is given for payment in full by *cash or check* at the time of service. We will provide a copy of your treatment plan fees.

Payment by Cash, Check, Visa, Mastercard, American Express or Discover – For portion that insurance does not cover.

Care Credit – Our Office Manager will review this confidential payment option upon request.

SENIOR CITIZEN DISCOUNT: We offer a 5% discount to senior citizens 65 and up.

MISSED APPOINTMENTS: We ask that you give at least 48 hours notice if you are unable to make your scheduled appointment. **Cancellation fees** will be charged for missed appointments or for those cancelled without at least 24 hours notice.

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and understand that **18% interest** will be applied annually to any outstanding balances of 90+ days. I authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if she so determines.

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctors in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and financial policy, and do realize the risks and limitations involved.

SIGNATURE: _____ DATE: _____