Our Kirkland Dental Insurance/Financial Policy

We are happy to assist you with your insurance. However, it is important to know that your insurance is a contract between you and your company. We can only estimate your benefits and if the estimate is less than expected you will be responsible for the remaining balance. Your estimated patient portion is due at the time of service.

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 works best for you.

☐ ***Payment in Full*** - A bookkeeping courtesy of 5% is given for payment in full by *cash or Check* at the time of service for those without insurance.

☐ ***Payment by Cash, Check, Visa, MasterCard, American Express or Discover*** – For remaining portion that *insurance* does not cover.

☐ *Care Credit* – Our Office Manager will review this confidential payment option upon request. We offer 6 and 12 month payment plans with 0 interest through this company.

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

MISSED APPOINTMENTS:
Please be sure to call us with at least 48 hours notice if you are unable to keep your scheduled appointment. We reserve the time and office staff for you and a cancelation fee of $100 per hour will be charged for missed appointments or those canceled without 48 hours notice.

Initial ☐

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 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: ______________