Apple Family Dental

2020 – 9th Avenue, Suite A * Longview, WA 98632 * 360-423-5580

FINANCIAL POLICY

Our office strives to provide the highest quality dental care at affordable prices. Our patients receive prompt attention and excellent service. We believe that a satisfied patient returns for additional services, refers others to the practice and pays their bill promptly. To maintain a good relationship with our patients, this office has adopted a written financial policy. The purpose of this policy is to eliminate confusion or misunderstanding concerning financial arrangements offered by our office and we do communicate this policy to every patient.

For those patients with dental insurance, we are happy to bill your insurance as a courtesy to you. Please note that your insurance contract exists solely between you and your insurance carrier. We will file your insurance claim, but we cannot guarantee any benefit or payment. Your insurance plan is a benefit to help you offset the cost of dental care and ultimately, you are responsible for the entire cost of your dental therapies. If you have detailed questions about your insurance policy, we recommend contacting your insurance company directly.

Below, is an overview of our office policy we would like you to understand: (Please initial)

_____ 1. We are a 'Fee-For-Service' provider: payment in full is due at the time of service, including the estimated portion of the amount insurance does not cover (this includes deductible and co-pay).

_____ 2. Our office accepts the following payment methods:

a. Cash
b. Check
c. Credit Card (Visa, MasterCard, Discover, American Express)
d. Care Credit (You may apply in-office or at home by phone or online).

_____ 3. A $30.00 charge will be billed to your account for any check returned by the bank for any reason. We will resubmit the check for payment to the bank one time. However, if funds are still insufficient, we will not accept payments by check from you in the future.

_____ 4. Delinquent accounts (if not paid at the time of service) of more than 90 days will be sent to a collection agency.

I have read and understand this financial policy and agree to all the terms described in it.a

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Patient Signature Date

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Printed name