BEAVERTON DENTAL CENTER

FINANCIAL AGREEMENT

Our staff is sensitive to the financial aspects of dental care and we strive to control these costs. We know that the cost of treatment is a delicate subject for many patients and we want you to feel free to discuss any concerns that you may have at any time. We have formulated our financial policies in an effort to make your experience as positive as possible.

IF YOU ARE COVERED BY INSURANCE:

- To maximize your benefits and send timely insurance claims on your behalf, it is essential that you provide our office with accurate and complete billing information before services are rendered. If this does not occur, our policies for uninsured patients will apply.
- **Your estimated co-payments and/or co-insurance must be paid in full at the time of service**. We do our best to provide you with an accurate estimate of these costs but it is your responsibility to verify the cost of treatment with your insurer.
- There are many insurance companies that offer dental insurance. Their plans can be complex. They may include deductibles, co-payments, co-insurance, and exclusions from coverage for certain procedures. We recommend that you verify coverage with your insurer prior to accepting treatment.
- **We will assist you with filing your claim in any manner that we can. However, if there is no payment from your insurance company within 45 days, you are responsible for full payment of any outstanding balance.** All unpaid balances will accrue interest at the rate of 1.5% per month or 18% per annum if left unpaid for 45 days or more. Balances over 90 days may be submitted to an outside company for collection.
- People are often under the impression that their insurance company owes the doctor for the cost of treatment. In fact, an insurance contract is between the patient and the insurance company only. Patients (or guarantors) are ultimately responsible for all charges, regardless of coverage or payment determinations.

IF YOU ARE NOT COVERED BY INSURANCE:

Payment in full is due at the time of service. Please see "Payment Options" for more information on the forms of payment accepted.

PAYMENT OPTIONS:

WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, DEBIT CARDS, CASH, PERSONAL CHECKS, OR CARE CREDIT. You may inquire about Care Credit at www.carecredit.com or by calling (800) 365-8295.

Please note:

- We do not offer in-house financing; and
- We require a social security number or a copy of your drivers' license for any fees not paid in full at the time of treatment.

STATEMENTS:

If you have a balance on your account, we will send you a statement. This balance is due in full upon receipt of your statement.

MISSED APPOINTMENTS:

There will be a $45.00 charge for any missed appointments or any appointments cancelled and rescheduled with less than 2 business days' notice. We reserve the right to refuse to schedule any patient that has missed 2 or more appointments.

INTEREST:

All unpaid balances will accrue interest at the rate of 1.5% per month or 18% per annum if left unpaid for 45 days or more.

PAST DUE ACCOUNTS:

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to an outside collection agency or credit bureau, you agree to pay all of the collection costs which are incurred. If we have to refer the balance to a lawyer for collection or if we pursue collections through small claims court, you agree to pay all lawyers' fees plus any and all court costs which we incur. You agree that any lawsuit filed in connection with this contract must be filed in Washington County, Oregon.

There will be a $35.00 service charge on any check returned by your bank unpaid.

AUTHORIZATION:

With my signature below, I authorize release of any relevant information necessary to submit my claim to my insurance company for processing. I also authorize any insurance benefits otherwise payable to me to be paid directly to Beaverton Dental Center.

ACKNOWLEDGEMENT:

I acknowledge that I have read the above, understand it, and agree to the terms of this contract.

_____ _____ _____

Signature of Patient or Responsible Party | Relationship to Patient | Date

_____

Name of Patient (Please Print)