Fall City Family Dental

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FINANCIAL AGREEMENT & DISCLOSURE

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility before treatment begins. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following financial arrangements.

1. **VISA/MasterCard**
2. **Patients with Insurance:** Estimated portion not covered by insurance is due at time of service.
3. **Patients without Insurance:** Payment for dental services is due at the time of treatment.
4. **Care Credit:** For patients requiring extensive treatment or for those who need flexible payment options, Care Credit Financing offers low interest payment plans.

FOR OUR PATIENTS WITH DENTAL INSURANCE

Because we understand that dental insurance plays a role in helping many people defray some of the costs of dental care, we would like to share with you the following information about dental insurance.

Please understand that our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. *Dental insurance plans do not correspond to individual patient needs, and as such; many routine and necessary dental services are NOT COVERED by insurance, even though you may need those services.*

In spite of what your plan says, we have found that many plans actually pay LESS than what you might expect. The benefits your plan pays are largely determined by how much your employer/union pays in premiums for the plan. The less they pay for the plan, the less you will receive. We are happy to submit your claims and help you receive the maximum benefits due you, but please understand that we cannot accept responsibility for collecting an insurance claim, or for negotiating disputed claims.

For treatment that requires dental laboratory services, a minimum down payment will be required at the initial appointment. All account balances over 60 days will be subject to a finance charge of 1% per month or a minimum monthly rebilling fee, regardless of insurance status.

I have read and understand the above financial policy. Regardless of insurance coverage, I am responsible for payment of all dental fees for myself and/or my dependents.

Signature____Date______________________