# Financial Guidelines

We would like to welcome you to our practice. We are committed to providing you with the best possible dental care. It is our goal for our patients to clearly understand their treatment needs, as well as their financial responsibility before treatment begins. We desire to make your dental treatment affordable for you. If you have insurance, we are pleased to help you receive your maximum allowance benefit. In order to achieve these goals, we ask for your assistance.

- We will bill your insurance company for your dental treatment as a courtesy. We ask that you please provide us with accurate information at the time of your appointment.

- We ask that the parent bringing in a child pay for all treatment and/or co-payments at the time of treatment regardless of custody agreements.

- We ask that you pay by cash, check, or credit card for all estimated co-payments at the time of treatment. For estimated co-payments greater than $200.00, we would be happy to assist you in making a financial arrangement.

- For existing balances, a finance charge of 1% per month (12% A.P.R.) fee will be assessed.

# Agreement of Financial Guidelines

I request and authorize Poulsbo Dental Center to provide me with dental care. I understand that I am personally responsible for the charges for the services I receive. I agree to make full payment for services I receive. I understand that regardless of dental insurance benefits, any treatment I receive is my financial responsibility. I agree to pay all reasonable attorney fees and costs of collection incurred by Poulsbo Dental Center if my account is not paid as agreed.

I hereby authorize Poulsbo Dental Center to bill my insurance carrier. I also authorize my insurance carrier to make payment directly to Poulsbo Dental Center.

Your signature below will acknowledge that you have read and understand our financial guidelines.

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Signature of patient (or parent if minor) Date

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Print name