Financial Policy

Pediatric dentistry is an important part of a child's overall health. Payment in full is due at the time of service unless other arrangements have been made. All payment arrangements must be made in advance with our financial coordinator. For your convenience, we offer several payment methods. We accept cash, checks and credit cards. If you have insurance benefits that will be helping you cover your dental care expenses, please provide us with your insurance information at your first appointment.

Methods of Payment

Cash Accounts: We offer a 5% discount for payment in full on the day of service. Any payment arrangements need to be made with our financial coordinator.

Credit Card: MasterCard, Visa, American Express or Discover.

Insurance Accounts: Your dental policy is a contract between you and the insurance company. We are not a party to that contract. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. You need to understand the scope and limitations of your insurance policy. We file your claims for you as a courtesy. To do so, we will need accurate insurance and employment information. Please provide this in a timely manner. Inaccurate information delays claims and can result in additional costs and inconvenience for you.

Care Credit: Convenient monthly payment plans allow you to pay over time with no annual fees or pre-payment penalties.

At the time you receive our services, you must pay all *estimated fees* and deductibles not covered by your insurance plan. If an additional amount is owed, your remaining balance must be received 30 days from the date we provided services. If your claim has not been paid within 60 days of the date of service, the entire balance is due from you. You then can be reimbursed directly from the insurance company.

You may be subject to the following administrative fees:

* Appointment cancellation with less than 48 hours notice: $25.00 (per scheduled appointment).
* Returned payment for non-sufficient funds: $25.00
* Household account is placed with a collection agency: $25.00
* If patient account is unpaid for greater than 90 days a 1.5% interest charge will be applied to the unpaid total owed monthly.

Certain insurance companies do not cover all services that our clinical team considers standard care. These services, if not covered by your benefits, will become your financial responsibility.

Should it be necessary to take action to collect any amount owing under this agreement, you will be responsible for all costs incurred to collect, including but not limited to, collection agency fees, attorney fees and court costs, and late fees on your unpaid balance. In addition, you will be asked to seek dental care elsewhere for your child.

I understand that, where appropriate, Credit Bureau Reports may be obtained. I have read, understand and agree to the provisions of this Financial Policy.

Signature: _____ Relationship to Patient: _____

Your Name (please print) :_____ Date: _____

Patient Name: _____ Patient DOB: _____

The laws of Washington State shall govern this agreement. In the event of a lawsuit regarding this agreement, the venue shall be proper only in Spokane County, Washington.