OFFICE FINANCIAL POLICY

Simply Smiles
1348 8th Street NE
Auburn, WA 98002
tel (253) 939-6900 • fax (253) 939-3667

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable we are pleased to offer you the following payment options.

Please select one of the following:

____ Cash or Check
____ Visa, MasterCard, Discover, American Express, Debit Card
____ Short-term and Long-term financing through CareCredit
____ Payment Plan – upon completion of a Credit Card Authorization

Kindly allow us to address any questions or concerns you may have. Our Financial Coordinator will be happy to discuss this policy with you in more detail if necessary to ensure that you have an exceptional experience in our office.

We will, as a courtesy, process your insurance benefits in our office. Any specific questions regarding your insurance benefits would be best addressed with your insurance carrier directly.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within sixty (60) days of date of service, regardless of whether or not my insurance benefits have been received. One percent (1%) per month interest, twelve percent (12%) per year (per RCW 19.52) will be charged on accounts 60 days from treatment date. I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data.

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Signature (responsible party) Date

_____

Signature (office representative) Date