Jeffrey J. Tufarolo, DDS

Cosmetic and General Dentistry
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Everett, Washington 98201
(425) 258-2834

It is our goal for all of our patients to be able to complete all their dental work. We do not want finances to be an issue for our patients. We understand that it is not always possible to pay your dental bill in full so we would like to explain our financial options. Please choose the one option that works best for you.

1. Payment is due at the time treatment is rendered. We accept Cash, Check, Visa, Mastercard, American Express, Discover and Care Credit cards. A 5% fee reduction will be given if full payment is made at the time of treatment with cash or check. We also offer a 5% Senior Discount to people 65 and older.

2. Dental Insurance- As a courtesy to you, we will complete your Insurance form and submit it to the Insurance Company. Your estimated co- payment (the amount not covered by your insurance company) is due at the time treatment is provided. If you fail to bring the required insurance information to your appts. We will ask that you pay the bill in full and be reimbursed from your Insurance company with paperwork provided by our office

   Our office does not guarantee that your Insurance Company will pay for the treatment you receive from our practice. If your claim is denied or alternative benefits are given, you will be responsible for paying the full balance amount left on the account at that time. Dental Insurance Companies usually have limitations and maximum payable amounts per year and for the most part will not cover the entire cost for all the dental treatment needed by most patients. It is our philosophy to offer our patients the best treatment possible for their dental needs. Often times Insurance companies will not cover 100% of these costs. It is our goal to maximize your Insurance benefits without compromising your dental treatment. We are happy to submit your Insurance claims for you but we cannot be responsible for collecting disputed Insurance claims or for negotiating disputed insurance claims but will do our best to help you with this.

   If your Insurance Company has not made payment within 30 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the Insurance Company and you or your employer. We have no control over the benefits your employer has chosen for you and cannot control the relationship between you and your Insurance Company.

3. Monthly Payment- We can offer a 3-month payment plan with a credit card on file. If you need to make long term payments we can offer financing with CareCredit, which offers up to 12 month no interest financing as well as longer terms with low interest rates. You must qualify for this option. Let us know if you are interested so we may conveniently qualify you in the office today.

Minor Patients- The adult accompanying the minor is responsible for the payment on the account. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-paid or other arrangements have been made.

Statements- All patients with an outstanding balance will receive a statement each month. There is a finance charge on all accounts 60 days overdue. All accounts over 90 days will be subject to our collection agency.

Returned Checks- A fee of $25 will be charged for any returned checks.

Broken Appointments- We ask for 48 business hours' notice to reschedule appointment s. You may be charged $100 per hour if you cancel short notice.

FINANCIAL AGREEMENT

I assign directly to Dr. Jeff Tufarolo, DDS, PS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dental practice may use my healthcare information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, legal fees and any other charges incurred to collect this account. Additionally, by signing this form I authorize Jeff Tufarolo DDS, PS to process credit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay.

Credit Card#_____ Exp. Date: _____

Name: _____ Card Type: _____

Security Code: _____ Payment Date: _____

Print Name: _____ Date: _____

Signature of Responsible Party: _____

Thank you for giving us the opportunity to serve your dental needs. If you have any questions about this form please let us know.