Whole Body Dental
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Bellevue, WA 98007

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Financial Policy

1. **Insurance** - We will submit your insurance claims as a courtesy to you. If your insurance plan cannot be verified, then payment is required in full at the time of service. Knowing your insurance plan is your responsibility. Insurance benefit amounts are subject to final approval by your insurance company; therefore, the amount due at our office is subject to change. All insurance benefits left unpaid after 30 days are your responsibility. Payment will need to be made by you to our office within 45 days to avoid adding interest.

2. All patients must complete our patient information form before being seen by the dentist. We obtain a copy of your insurance and driver's license to provide proof of insurance and identity. If your insurance changes, please notify us before your next visit so we can confirm eligibility and make changes to your file.

3. **Payment is due in FULL on the day of treatment**. Credit Card payments (Visa, MasterCard, and Discover,) Cash and Checks are accepted.

4. It is very important that you keep your appointment. **Missed or cancelled appointments will be charged $45 per 30 minutes** of the scheduled appointment time. ($90 for 60 minutes). Appointments must be **cancelled within a 48 business hours** time period. We require the advanced notice so that we may see another person in need. Please remember that this appointment time has been reserved for you.

5. If your insurance does not pay for your claim in 45 days, the balance will automatically become your responsibility. We will try our hardest to be your insurance advocate. Interest will be charged at the rate of 1.5% per month, 18% annually.

6. Credit balances will be refunded within 30 days when requested. The same method of payment (Visa, MasterCard, Discover, cash or check) will be used to process the reimbursement, according to the patient's original payment method.

7. There is a **$30 returned check fee** if your check is returned due to insufficient funds.

8. All records, x-rays, and photographs are the property of the clinic. A request for records may be made; however, an administration fee may apply.

I, _____, the undersigned patient (or legal responsible party) authorize dental treatment and assume financial responsibility for all charges on my account. I authorize the release of payment from my insurance company to be made payable directly to the dentist.

Signature: _____ Date: _____