Financial Information

We have outlined our policies to help answer questions that you may have as to options available for paying for your dental care. Feel free to discuss with our financial manager any additional concerns or questions you may have.

Uninsured Patients: Payment is due at the time of your visit. If this is not satisfactory for you, see our financing information.

Insured Patients: As a courtesy, we are happy to bill your insurance for you. Any estimated charges not covered by your insurance are due at the time of service. Please bring in your insurance booklet, so we can give you an estimate that is as accurate as possible. Your insurance is a contract between you and your insurance company. You are responsible for your charges, regardless of the status of your insurance claim. Interest will accrue on any balance that is over 60 days.

Injury: Please inform us if your visit is for an injury that you have received at work or while in an automobile. We will have to preauthorize your dental care and may need to bill a different insurance than your normal dental policy. In order for us bill this for you, please provide us with a name and phone number for your accident insurance.

Missed Appointments: In order to accommodate our patients, we ask that you notify us within 24 hours of any appointments that need to be rescheduled. Appointments cancelled with less than 4 hours notice are subject to a $25.00 charge.

Finance Charges: Accounts not paid within 60 days of the date of service are subject to a monthly finance charge.

Returned Check Fee: Any check returned as unpaid will be charged an NSF (Non-sufficient funds) fee.

Methods of Payment: We accept cash, personal checks, Visa, MasterCard, American Express, and Discover. We can assist you in setting up payments with Care Credit.

_____I have no dental insurance and will be paying my expenses on day of service.

_____I have dental insurance and would like you to bill them for me. I will pay any estimated charges not covered by my insurance on the day my work is done. I understand and agree that if for some reason my insurance does not pay what is expected, I am responsible for the balance owed. I will pay this balance with in 20 days unless prior arrangements have been made.

_____I have a coverage under the Oregon Health Plan.

I authorize release of all necessary dental information to my insurance company and payment of all claims to be sent directly to the dentist. I understand and agree that I will be charged interest for any balance due over 60 days.

Signature:_____ Date:_____