# MAY CREEK FAMILY DENTISTRY

1620 Duvall Ave NE #A
Renton, WA 98059
425-271-6002

## FINANCIAL POLICY:

Thank you for choosing our office to provide you with your dental care. The following is a statement of our Financial Policy, which we require our patients to sign after reading. After an examination and diagnosis we will provide you with an estimate of the recommended treatment for you.

- **TYPES OF PAYMENTS ACCEPTED:** We accept cash, check, MasterCard, Visa and Discover

- **DENTAL INSURANCE:** As a courtesy we will gladly file your insurance claims and accept assignment of dental benefits. Most insurance companies will not cover 100% of all dental treatments. We will do our best to estimate your portion of the treatment. Please be aware that we are only able to approximate your portion due to the large number of insurance companies and the periodic changes within their contracts. The portion not covered by insurance is due at the time the treatment is performed unless otherwise agreed on. To be able to file your claims, you must provide us with your insurance card and all pertinent information required filing your claims. Remember that your insurance policy is a contract between you, your employer and the insurance company. You are only responsible for our fees and not what the insurance company allows. We do not file claims for your medical insurance. Patients without insurance coverage are responsible for their fee the day of treatment.

- **MISSED APPOINTMENTS:** Broken or missed appointments prevent other patients from receiving the dental care that they deserve. We take them seriously so please be considerate and give our office at least 48 hours' notice if you need to change an appointment. Appointments missed or broken without the 48 hours' notice may be charged a fee up to **$100.00.**

- **RETURNED CHECKS:** There will be a fee of $30.00 charged to your account for checks returned from the bank.

**MINOR PATIENTS:** The parent or guardian accompanying the minor is responsible for the full payment. In the case of a divorce or separation, the parent who brings the child to the office is the responsible party. We will not attempt to collect payment from a parent that is not present with the child in the office. The patient or guardian agrees to be fully responsible for the total payment for all treatments performed in this office.

I certify I have read, understood, and agreed to this Financial Policy and Agreement.

Signature: ________________________________________ Date: ______________________