1002 Park Ave N, Suite H • Renton, WA 98057 • Phone: (425) 988-2808

FINANCIAL AGREEMENT

This is an agreement between Renton Children's Dentistry, a Washington Professional Corporation, and the patient named on this form.

By executing this agreement, you are agreeing to pay for all services that are received.

Payment options if you have no insurance:

A. You may choose to pay by cash, check or credit card on the day that treatment is rendered.
B. On extensive treatment, you may choose to inquire about our credit program.

Payment Options if you have insurance:

A. Your deductible and any out-of-pocket portion is due on the day that treatment is rendered. You may choose to pay this by cash, check or credit card.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will be happy to bill your insurance company as a courtesy to you. Although we will to the best of our ability estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by your insurance. We will attempt to collect from your insurance company for up to sixty days at which time the balance becomes your responsibility.

Payments: Unless other arrangements are approved by us in writing, the balance on your statements is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance and new charges to the account and any payment or credits applied to your account during the month.

Returned Checks: There is a fee (currently $25.00) for any checks returned by the bank.

Missed Appointment Fee: Patients who do not show up for an appointment or cancel within less than 48 hours will be charged.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agreed to pay all of the collection costs, which are incurred.

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: _____ Date: _____

Signature: _____

Responsible Party (if not patient): _____

Witness: _____