



OFFICE FINANCIAL POLICY

1716 South Gold Street
Centralia, WA 98531
tel 360-623-1350 • fax 360-623-1353

In our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment.

- ☐ 5% Accounting Courtesy for full payment at time of service with cash/check for amounts greater than \$200.
- ☐ We gladly accept Visa / MasterCard and American Express/Discover
- ☐ Outside Financing
 - ☐ Flexible Monthly Payment Options
 - ☐ Interest Free Options
- ☐ Fairway Dental Care Membership Smile Club members receive 15% savings

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices. **WE** will always present you with the best dental solution possible to treat your personal situation.

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within ninety (90) days of date of service, regardless of whether or not my insurance benefits have been received. One percent (1%) per month interest (12% per year) will be charged on accounts thirty (30) days from treatment date. I agree that there will be a \$35.00 fee for a returned check. I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data.

I agree that I will give at least two (2) business days, advance notice for changes to my appointment reservation time and that a \$50 per hour fee may be charged for failure to keep my scheduled appointments without sufficient notice.

We are here to assist you in any way possible. Please make your questions and concerns known to our team... Our goal is to ensure that you have an outstanding experience.

Signature (responsible party)

Date