Dr. Marie Durflinger Bella dental care Dr. Rima Abifaker

PATIENT AGREEMENT

We understand that dental treatment may involve an investment of time and money for you and your family. To assist you in meeting this financial obligation, the following payment options are offered:
Please choose and check a method of payment, which is most convenient for you.

____VISA/MC/Discover ____Check _____CareCredit Card w/approval

When services that involve lab-work are needed, ½ of fee (co-payment) is due the day treatment is started and the remaining balance is due on completion of treatment. ***There is a $30 charge for returned checks. Fees are subject to change.*** If you have dental insurance, you will be responsible at that time for any co-payment and-or deductible that may apply for services completed the same day. If you do not have insurance, the entire fee is due on the day of service.

Billing Policy

A monthly statement will be sent at the first of each month specifying what services were performed, the amount billed to your insurance company (if applicable) and your total balance. Finance charges are automatically assessed to entire existing balances at 60 days from the date of service. This charge will be added to the account balance even if insurance payments are pending. Finance charges may be avoided by taking care of all charges at the time of service and having your insurance company pay benefits directly to you.

Dental Insurance – We go the extra mile***

For the convenience of our patient, we will submit all claims for treatment. However, your help in making sure your dental insurance company pays the claim is required. We do want to remind you, that all patients are fully responsible for payment of accounts, and that we do not render services on the basis that insurance companies will pay any or all fees. Also, please understand that the guidelines and allowable dental maximums are set by your insurance policy. As a courtesy to our patients we try to give an ***estimate*** of what your insurance company may pay for services from information we receive over the phone**, but in no way are we responsible nor ever guarantee payment from any insurance company.** Our fees for service are the same for all patients regardless of the extent, type of treatment or whether they have insurance coverage or not. ***Please, remember your insurance policy is your responsibility. It is a contract between you and the insurance company/employer.*** If your claim is denied, as a courtesy, we will resubmit the claim to your insurance for a second time. If your insurer ***denies*** coverage due to incorrect policy holder information provided by you to our office, the balance of the claim will become the patient's responsibility. We will be glad to provide all the information when/if an attempt is made to process the denied claim. As a reminder, we will make every effort to help you obtain your benefits; we cannot compel your insurer to pay.

I hereby authorize my insurance company to pay directly to either Dr. Marie Durflinger or Dr. Rima Abifaker, benefits due me out of indemnity under the terms of my policy.

_____ Date: _____

Signature of guarantor of payment/responsible party Relationship to Patient: _____

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PATIENT AGREEMENT
Continued-

Cancellation Policy _____ Initial

In order to ensure you and other patients' uninterrupted treatment, it is necessary for patients to adhere to all scheduled appointments. Once you have made an appointment, please remember this time is reserved for you. We ask that you make your very best effort to notify the office at the earliest possible time if an appointment change is necessary. There will be a charge of ***$100 per hour*** on any failed appointment or if notification is not received within our 2 business day of your scheduled time. **(Business Days Monday-Friday)** ***Fees are subject to change.***

In the event that legal action is taken to enforce any aspect or section of this agreement, the venue shall be King County, Washington, and the prevailing party shall be entitled to collection costs, legal fees and court costs.
I have read, understand, and agree to the above policies.

_____ Date: _____

Signature of guarantor of payment/responsible party Relationship to Patient: _____