OFFICE POLICIES

Washougal Family Dental

Please email completed PDF files to: info@washougalfamilydental.com

Our philosophy is to provide the highest quality of patient education and dental care to all of our patients. Our hope is by providing you the following information we can prevent misunderstandings to ensure you a positive experience. Please feel free to let us know if you have any questions or concerns. (360) 835-2178

EXPECTED PAYMENT

To keep our fees to you as low as possible, we ask that payment be made at the time of service. For your convenience an estimate for services will be prepared in advance of your appointment/s to ensure you opportunity to plan for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the care they need and want.

INITIALS

DENTAL INSURANCE

We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We request that you familiarize yourself with your insurance benefits, and provide us the correct information to assist you with the submittal of claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 45-60 days. Please realize that your insurance is a contract between you, your employer, and the insurance company; therefore, we cannot guarantee coverage and your assistance may be requested. Not all services are covered benefits in all contracts; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductibles, limitations, or maximums.

INITIALS

PAYMENT OPTIONS

For your convenience we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile. Please identify which form of payment is most convenient for you at the time of service.

PLEASE NOTE: A $25.00 NSF fee will be charged for all returned checks. Should you desire a monthly payment plan we invite you to complete a simple finance company application. There are no application fees or a down payment and the loan can be interest-free.

- ☐ CASH/CHECK
- ☐ MASTERCARD
- ☐ VISA
- ☐ EXTENDED PAYMENT
- ☐ OTHER

PAST DUE BALANCES

If applicable balances owing from a prior visit where insurance is not pending, or an insurance payment has not been received within 90-days, or the account has been sent to collections is considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. Balances over 90-days may be subject to a rebilling fee.

INITIALS

CANCELLATIONS

If you are unable to keep your reserved appointment we request a 48-hour courtesy notice. Early notification ensures that we can offer you a more convenient appointment and allows us sufficient time to accommodate the needs of another patient. It is important that we fill the time previously reserved for you. A missed appointment fee $50.00 will be charged when advanced notice is not provided. We realize that emergencies do occur and we will be flexible under those circumstances. Please be advised that (3) missed appointments without the requested notice within a 12-month period may result in dismissal from our practice.

INITIALS

CELL PHONES

We ask that cell phones and pagers be turned off at all times while in the treatment area. If being available for an emergency during your reserved appointment is necessary, please leave our office telephone number so you can be reached. Should an unfortunate emergency arise we would be happy to notify you in the treatment area immediately.

INITIALS

INFORMATION CHANGES

To ensure your records are current please notify us of any changes related to medical history, telephone number/s, address, employer or insurance information as they occur.

INITIALS

My signature indicates that I understand that policies as outlined and any questions I have with regard to office policies have been answered.

SIGNATURE OF RESPONSIBLE PARTY OR PATIENT

DATE

My signature indicates that I have reviewed the office policies with the responsible party and/or patient.

SIGNATURE OF STAFF MEMBER OR DOCTOR

DATE

If filling out and submitting PDF online: Typed initials, and first name/ last name is sufficient for approval.

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