MOUNTAIN VIEW
DENTAL CENTER, P.S.
708 E. Mountain View Ave.
Ellensburg, WA 98926
(509) 962-2755

PAYMENT POLICY

ALTHOUGH HEALTH CARE REFORM REQUIRES US TO HANDLE ACCOUNTS IN A CERTAIN MANNER, IT IS NOT OUR INTENT TO CAUSE YOU ANY UNDUE HARDSHIP. IF YOU HAVE ANY QUESTIONS, PLEASE ADDRESS THEM AT THE TIME OF SERVICE.

PAYMENT IS DUE AT TIME OF SERVICE. Our goal is not to let expense prevent you from benefiting from the quality of care you desire and need. We also realize that every patient's financial situation is different. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

WE DO ACCEPT VISA/MASTERCARD, DISCOVER, AMERICAN EXPRESS, CARE CREDIT, DEBIT CARDS, CASH OR CHECK.

FINANCIAL ARRANGEMENTS:

We are well aware that situations arise that require extended financial arrangements. Special arrangements may be made with our Financial Coordinator prior to the services being rendered. Treatment plans are available for all dental treatment.

PATIENTS WITH INSURANCE:

IF YOU HAVE DENTAL INSURANCE, CONGRATULATIONS IT IS A WONDERFUL BENEFIT. CO-PAYS AND DEDUCTABLES ARE DUE AT TIME OF SERVICE.

Insurance is a contract between you and your insurance company. As a courtesy, we will file your claim with your primary insurance company provided you give us the correct information required. We cannot accept responsibility for collection of an insurance claim or negotiating a disputed claim.

If your insurance fails to pay, it is your responsibility to pay the amount due, and deal with your insurance company directly. You are responsible for the payment of your account balance within the usual time limits of our policies. Delay in insurance payment is no excuse for non-payment of your account.

PATIENTS WITH OUTSTANDING BALANCES:

Patients that currently have a balance with our practice will be asked to establish a regular, monthly payment plan (not to extend more than 3 months) to address these outstanding balances.

FINANCE CHARGES

If I do not pay the entire balance on my account within 90 days of date of service, a finance charge of 1.5% on the balance then unpaid and owed, will be assessed each month thereafter. I realize that failure to keep my account current may result in Dr. Jared Condie being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

NO SHOW FEE

IF UNABLE TO KEEP AN APPOINTMENT, kindly give 24 hours notice. Otherwise our office reserves the right to charge a $50.00 fee for time reserved. Please do not cancel appointments through email or text messaging.

TREATMENT PLANS

Please be advised our office is limited to information we can receive from your insurance company. Treatment plans are estimates only. Co-pays are based upon these estimates. Our office will inform you of any changes with your treatment plan as they occur. However, it is the patient's responsibility to know their insurance exclusions, limitations and their usual and customary fee schedules as these items are rarely provided to our office.

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I further understand that if collection action is taken on my account and/or legal action is necessary, the venue will be in Kittitas County.

By my signature below, I acknowledge receipt of this payment policy, authorization and release.

_____ _____

Patients Signature **Date**