



# Payment for your dental care

*We believe in partnering with our patients to discover options that allow you to achieve the level of dental care you desire. Our guidelines below provide information on how we can best assist you in your decisions.*

## PAYMENT OPTIONS

**Payment is due at the time of service.** You can pay with cash, check, credit/debit or HSA/FSA.

**All treatment recommendations made in this practice are based solely on your clinical needs and your wishes.** We encourage you to consider that exceptional dental care as an investment that will continue to your overall health for many years to come. If you have any questions about how we can help you make that investment, please let us know.

**Payment over time of treatment.** If your treatment requires a major investment or multiple appointments over an extended time, we can set up a simple payment structure that allows you to spread out the fee in installments starting with your initial approval of treatment and ending with your final visit for that treatment. If you wish to explore ways to extend payments beyond the time of scheduled treatment, we can help you understand your options for financing your care when needed.

## IF YOU HAVE DENTAL BENEFITS:

To the best of our ability, we will assist in understanding and maximizing your benefits. As a courtesy, we prepare and electronically submit all necessary forms to your dental benefit administrator. Our estimate of your out-of-pocket costs will take those benefits into consideration. **Please remember, we cannot guarantee the amount of your benefit and there may be a remaining balance for which you are responsible.** Balances remaining after 90 days will be the patient's responsibility to pay.

## RESERVATION & CANCELLATION:

When you schedule your appointment, we reserve time specifically for you and your scheduled procedure. If you are unable to make your appointment, we request that you notify our office at least **48 hours notice** prior to your reserved appointment time. Missed appointments (no-shows) or cancellations under 48 hours may result in a \$65 charge and we may ask for a deposit before booking your next appointment.

## **AUTHORIZATION AND RELEASE**

I authorize Mountain View Dental 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. I authorize and request my insurance company to pay directly to the dentist or dental office the insurance benefits otherwise payable to me. I understand that my dental insurance company may pay less than the actual bill for services. I **agree to be responsible for payment for all services rendered on my behalf or my dependents.** If I do not pay the entire balance on my account within 90 days from the date of service, a finance charge of 0.75% 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. Joshua Kirk being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional service. In the case of default on payment of my account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances. I further understand that if collection action is taken on my account and court action is necessary, the venue will be in Kittitas County.

By my signature below, I understand and agree to the above conditions, authorization and release.

\_\_\_\_\_  
Patient Signature (or Parent/Guardian)

\_\_\_\_\_  
PRINT Name

\_\_\_\_\_  
Date