FINANCIAL POLICY, ASSIGNEMENT AND RELEASE

Payment for services is due at the time services are rendered, unless prior arrangements have been approved by the office manager. All accounts going over 90 days are subject to collections. A service charge of 18% annually may be applied to accounts more that 90 days past due. If this agreement is placed in the hands of a collection agency or an attorney for collection, the non-prevailing party agrees to pay reasonable attorneys fees and costs as set by the court having jurisdiction, including cost in any appellate court.

We accept cash, checks, money orders, Visa, Discover, and Mastercard. We also accept CareCredit as a means of financing dental treatment when necessary. All returned checks will be assessed a $25 NSF fee.

We are happy to process your insurance claim for you. However, we must emphasize that our relationship is with you and not your insurance company. Any outstanding bill is ultimately your responsibility.

Except in emergency situations, you can expect us to be on time for you. We appreciate the same courtesy. If you are unable to keep your appointment please notify us at least 24-48 hours in advance. We reserve the right to charge a $35 fee for repeat broken appointments, as we have reserved time especially for you in our schedule.

Your signature consents to the terms herein and authorizes the following: (1) that any available insurance benefits be paid directly to Cascade Dental, (2) the release of my dental health care information for any of my dental health care insurance claims, (3) the use of my dental records by my dentist in any professional manner that he/she determines necessary, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "my images"), and (5) that Cascade Dental may use these images in insurance claims, scientific papers, demonstrations, and/or presentations without compensation to me. I agree that, to the extent the cost of the dental care provided by Cascade Dental is not covered by insurance, I am obligated to pay Cascade Dental such uninsured cost in accordance with these payment terms and policies. Finally, I certify that I have read and understand the contents of this policy.

SIGNATURE – Patient/Guarantor Date

Dental Insurance Information (if applicable)

Do you have dental insurance? □ Yes □ No If yes, please provide insurance card to front desk

If primary policy holder differs from patient, complete the following:

Name of insured:_____ Birth date:_____

Relationship to patient:_____ Gender:_____

Employer:_____ Occupation:_____

Insurance company:_____ Additional dental coverage?_____