OFFICE FINANCIAL POLICIES

WELCOME to our office. One of our goals is to make your financial portion simple and easy to understand. We want to provide you with a clear understanding of how your insurance benefit package works, and our office financial policies. Signing this document means you understand the financial policies, you consent to the terms, and all of your questions regarding your benefits have been answered.
I understand that payment is due at time of services. Van Ness Family Dentistry reserves the right to charge a $10.00 fee for billing if payment is not received the day of services.

I understand that Van Ness Family Dentistry will file all claims with insurance company. We can give you an estimate of your coverage; however, **WE CANNOT GUARANTEE** that the insurance company will provide the full estimate coverage. You will be responsible for any remaining portion the insurance company does not cover.

If you refer a new patient, we will give you a $50.00 credit towards your treatment.

In the event of a balance due, After 90 days, I understand that I will be referred over to a collection agency. In the event of litigation by Van Ness Family Dentistry or its (collection agency) to enforce collection of any outstanding debt, the guarantor will be responsible for all reasonable attorney and collection agency fees, turned over, late fee collection charge of $25.

Your payment options include: Visa, MasterCard, Cashiers check, or money order.

CONSENT AND AGREEMENT

As a consenting adult, I agree to permit Dr. Kamanin and Van Ness family Dentistry staff to provide comprehensive dental care to myself, child (children), or legal ward as applicable. Comprehensive dental care (examination) includes soft and hard tissue exam of the head and neck, periodontal (gum) exam, oral cancer screening, and X-rays (full mouth).
I understand that Van Ness Family Dentistry maintains the right to discontinue dental treatment for any appropriate reasons such as refusal of X-rays, refusal of periodontal treatment, excessive cancellations, failed appointments, or failure to pay. In such cases, the patient or parent/guardian agrees to accept full responsibility for pursuing alternate dental care. A letter shall be sent informing you that treatment is discontinued.
THERE IS A $35.00 CHARGE PER PERSON FOR ALL FAILED APPOINTMENTS OR CANCELLATIONS WITHOUT A 24 HOUR NOTICE. Charges will be applied to your account without a notice. We request that you call in advance upon changes in your busy schedule.
I understand that all records pertaining to the treatment and diagnosis of are property of Van Ness Family Dentistry. Records and X-rays will be duplicated upon request with a customary fee applied for duplication.
A parent or guardian much sign consent for treatment of a minor. <u>You are required to be present during the entire session of all dental care (exams, X-rays, or treatment) for the minor.</u>
I will be expected to pay for treatment I receive and that Van Ness Family Dentistry reserves the right to revise fees at any time, for any treatment which has not been started. During the course of my dental care unforeseen complications or new conditions may arise that may require treatment in addition to the procedures listed on my treatment plan which may result in higher cost. I understand that in the event my treatment becomes too complex to manage, it may be necessary for me to be referred to one of the specialists in order for me to receive the appropriate care. Should this occur, I understand that I will be expected to pay the specialist's fee.

I understand the consent and the office financial policies. I consent to the terms of agreement and that all of my questions regarding the financial portion, and consent and agreement have been answered to my satisfaction.

SIGNATURE_____DATE_____