

# Seattle's Family Dentistry

10416 Aurora Avenue North, Seattle, WA 98133

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## Our Goal, Office and Financial Policy

Thank you for choosing us for your care. Our goal is to provide complete dental care for our patients. We are kind and respectful with the purpose to make each visit as comfortable as possible. In return we expect our visitors and patients to give the same consideration towards Dr. Goraya and staff.

**No Insurance:** Full payment is due at the time of service. If you pay cash a 10% discount is available towards your bill. Unfortunately, we do not bill or finance any dental treatment. Payment plans are available through [www.carecredit.com](http://www.carecredit.com).

**Dental Insurance:** We are willing to help you maximize your benefits allowable under your plan. In order to achieve this goal, we need you to know your own insurance plan and guidelines. Your photo ID and insurance card must be present before services are rendered. If we are not contracted with your insurance plan we may require payment in full and then you will be reimbursed by your insurance carrier. We will bill your insurance carrier as a courtesy. Your co-pay and deductible are due at the time of service \_\_\_\_\_ (Initial). If your insurance company denies your claim we will **not** get involved with any dispute between yourself and insurance company. You are responsible for the debt incurred, the services rendered, and the complete payment of the bill. All balances are to be paid within **15 days** after insurance denial. Your dental insurance benefits were verified by our office according to information provided by you. The benefits quoted by your insurance company are just an estimate and are not a GUARANTEE OF COVERAGE. You will be responsible for any amount not covered. \_\_\_\_\_ (Initial)

**DSHS Provider One Cards:** Your photo ID and DSHS Provider One card must be **active** and presented before services are rendered. If you do not have your DSHS Provider One card or ID we will reschedule your appointment.

**Discount Plans or Reduced Plans:** Your photo ID and membership card must be presented before services are rendered. Payment is due in full at time of service.

**Labor & Industry Claims:** If you are establishing a new claim you must bring a signed L&I claim form and your photo ID. Any existing claim must have a claim number and date of injury. It is **your** responsibility to notify the department if you are changing dentists mid treatment. If your claim is rejected, you are responsible for **full** payment within **15 days** of denial

**Payment Options:** We accept Cash, Visa, Master Card, American Express, and Discover with Washington state driver's license.

**Delinquent Accounts:** Balances older than 60 days will be subject to interest charges of 1.5% per month. Your account will be submitted to a Collection Agency and will add their fees accordingly. Your communication and payments will be done through said agency. Please **do not** ignore any statements received from us. It is better to inquire about your account than assume all is well. Collection Agencies are our last resort. Please inform us of any address or phone number changes so we may better keep you informed.

**Late and/or Missed Appointments:** All late attendees to scheduled appointments may receive a late fee of \$40.00 and possible rescheduling. If you are late to your appointment it causes unnecessary waiting time for other patients and disrupts our scheduling. If you miss your appointment or cancel without 24 hour notice there will be a \$40.00 charge per person. \_\_\_\_\_ (Initial). The charge must be paid before we reschedule.

**Emergencies:** Unfortunately we have occasional emergencies that will cause extra waiting time for nonemergency patients. We apologize for this inconvenience.

**Transferring Records:** Please inform our office if you have chosen to pursue your care elsewhere. We will need a signed "Release Form" before any records are released for mailing to another dental office. Confirmation letter will be sent to confirm your decision.

**Termination:** We value our patients and seek to continue care to the best of our abilities. By violating this office policy it will result in termination of your "active" status. A termination letter will follow.

**Minors, Disabled, Residence Care Patients:** A Parent or guardian (over 18years old) must stay on premises during the appointment. This is for legal, medical and emotional purposes for the minor. If guardian is with a minor a letter of authorization dated for dental work along with name of the guardian must be stated. Small children must not be left unattended, no running around the office is allowed. The disabled or resident care patients must have a caseworker or caregiver with them throughout the service.

I HAVE READ, UNDERSTOOD, AND AGREE TO THE ABOVE TERMS AND POLICIES.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date