Manpreet Dhaliwal, DDS **Christine Tran, DDS**
Four Corners Family Dentistry 425-413-8144

OFFICE POLICIES

Our goal is to provide you with the highest quality dental care in a fun, caring environment. We want to have a long-term relationship with each patient to provide a preventive dentistry program. To facilitate your treatment in our office, we will do our best to help you understand your investment in your dental health. In order to prevent any misunderstandings, please read this carefully. Your signature at the bottom indicates you are aware of our office procedures. We welcome any questions you may have.

Payment Options and Financing: Payment in full is expected at the time of service. To assist you with your investment in your dental health, we offer the following financial options for patients without dental benefits:

1. We accept Visa, MasterCard and CareCredit.
2. We offer extended financial arrangements up to a maximum of 90 days interest free. For this option, an auto-pay credit card authorization must be on file
3. If you require a more extended monthly payment plan, 3rd party financing is available.

Insurance Billing: Please provide us with your dental benefit plan information. We are happy to assist you in obtaining maximum dental benefits by preparing and submitting your claims. Please note that there are some plans in which we do not participate as a preferred provider. *We require payment of deductibles and coinsurance to be paid at the time of service.*

At your request, we will submit a copy of your treatment plan to your insurance carrier so that you can receive an estimate of benefits before starting treatment. However, it is important to note that this predetermination of benefits is not a guarantee of payment by your insurance carrier; and ultimately the total cost of your treatment is your responsibility. If the insurance carrier disputes payments, they will become the full responsibility of the patient after 90 days from the date of service. We cannot be responsible for collecting your insurance benefits or negotiating a settlement of a disputed claim, although we will do our best to assist you during the process.

Please read and initial the following:

_____**Finance Charges**: Account balances over 90 days from the date of service are subject to a 1% monthly finance charge.

_____**Appointment Reminders:** As a courtesy, we routinely call to remind patients of their appointments one to two days in advance. However, we do expect our patients to be responsible for keeping their appointment whether or not a reminder call was received.

_____**Appointment Changes:** Your appointment time is reserved exclusively for you and we appreciate your commitment to keep it. We do understand that at times an appointment must be changed, but require 24 business hours notice to avoid a $50 per hour cancellation fee.

_____**Returned Checks:** There is a $25.00 charge for any returned checks.

Authorization: I have read, understand and accept the information presented above.

Signature Printed Name Date

Insurance Assignment and Release

I, the undersigned, have dental insurance, and assign directly to Manpreet Dhaliwal, DDS and Associates all dental benefits, payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature Printed Name Date