Valley Dental Group
Gentle Family Dental Care
Brian Kane, DDS ● Doris Chan, DDS ● Luke St. Marie, DDS
17900 Talbot Rd. S #103 ● Renton, Wa 98055 ● Phone (425) 271-1727
Fax (425) 271-1763 ● Email frontdesk@valleydentalgroup.com

FINANCIAL POLICY

PAYMENT

- Full payment is due at time of service.
- We accept cash, checks, Visa, MasterCard and Discover.
- Care Credit (Credit you can apply for over the phone or online.)

INSURANCE

You are required to pay a deductible and a percentage that insurance does not cover at time of service. We do accept assignment of insurance benefits and will be happy to submit a claim form to your insurance company for you. We cannot bill your insurance unless you bring all insurance information and if needed, an original claim form. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. We provide administrative services in collecting from your insurance company. You are responsible for all costs for dental care whether covered by insurance or paid directly by you. Our office strives to provide quality, dependable, and esthetic dental care. The least expensive insurance solution is seldom in the best interest of your health. It is important to understand that insurance companies draw all contracts with your employer. Their plan may not fit your overall dental health requirements. Insurance companies can and do apply clauses that limit their level of coverage, placing sole payment responsibility on the patient. If a problem arises our front office staff may suggest some steps towards improving your dental plan. Any balance owed after insurance pays is your responsibility. If your insurance company has not paid your account in full within 45 days, the balance is then your responsibility. Please be aware some and perhaps all of the services provided may be a non-covered service under your insurance policy. Secondary insurance is submitted after primary insurance payment has been received.

PRE TREATMENT ESTIMATE

We will estimate the insurance portion and the patient portion of charges to the best of our expertise. This is an approximate computation of probable cost and does not guarantee payment by your insurance company. You are ultimately responsible for full payment.

MINOR PATIENTS

The adult accompanying a minor and the parent or guardian(s) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan.

MISSED APPOINTMENTS

Unless cancelled with at least 2 business-day notice Monday through Saturday, our policy is to charge for missed appointments a minimum of $50.00 for every hour. Please help us serve you better by keeping your scheduled appointments.

****Time is valuable to all of our patients, if you have any of the state insurances and you No-Show an appointment we will not charge our missed appointment fee. However; in order to save time on future appointments for other patients, we will NOT be able to reschedule any future appointments for you.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____/_____/_____

Signature of Patient or Responsible Party Date

AUTHORIZATIONS

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry our payment activities in connection with this claim.

_____ _____/_____/_____

Patient/Guardian Signature Date

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above named dentist of dental entity.

_____ _____/_____/_____

Subscriber Signature Date