Bernard S. Pak, DDS
312 – 11th Ave. West, Suite 101
Kirkland, WA 98033

FINANCIAL AGREEMENT

Patient Name: Today's Date:

Payment for the patient's portion of dental services is due at the time the service is rendered. Our office will be happy to process your insurance claim for you. Insurance estimates are provided as a courtesy, however are estimates. In the event that your insurance carrier pays less than the estimated amount, then you, the patient or guarantor, is responsible for the full unpaid balance. Pre-determinations are performed upon request, however are not a guarantee of benefits. We accept cash, checks and for your convenience MasterCard, and Visa.

Our staff will do their best in going over your treatment and answer any questions relating to your insurance. Please understand:

1. Your insurance is a contract between you, your employer and the insurance company.
2. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. **It is the patient's responsibility to review and know their policy and its limitations, as it is an agreement between you (the patient) and your insurance company.**
3. Our fees are considered usual, customary and reasonable and fall within the acceptable range for most dental insurance companies and our demographic area.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

- Missed/Broken Appointment: There is a $45 cancellation fee for time reserved for appointments missed, broken, or cancelled without 48 hours advanced notice given.
- Checks Returned and NSF: There is a $30 charge for check returns and NSF per incident.
- Finance Charge: Over 30 day balances are subject to a 1% interest rate per month, 12% per year charge on your account.

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I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for all dental services rendered. I have read all the information on this financial agreement and have completed a health history form as needed. I understand that it is my responsibility to inform this office of any address or contact phone number changes on my account. I certify that the information is true and correct to the best of my knowledge

I authorize and give consent for dental treatment of the person named above and agree to pay all fees and charges for such treatment and services rendered. I agree as the parent and/or legal guardian of the minor receiving dental care at this office, I am ultimately responsible for all payments of fees for dental services rendered to the minor in my care.

I authorize this office to release information relating to my dental care to my insurance company. I desire that dental insurance check payments to be sent directly to the dentist.

Patient Signature (Parent or Guardian) Date

Witness / Reviewed By Date