CONSENT TO CARE AND FINANCIAL AGREEMENT

Bernard S. Pak, DDS, PS
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Kirkland, WA 98033
425.893.9500
www.KirklandSmiles.com

Patient Name:_____ **Date:**_____

CONSENT TO TREATMENT: I consent to receive care and treatment from providers at Kirkland Smiles Dental Care which may include dental treatment, x-rays, and medical treatment as necessary.

GENERAL: Kirkland Smiles Dental Care is committed to providing the highest level of dental care and customer service for our patients. Payment for the patient's portion is due at the time of service. This includes estimated patient portions, deductibles, and co-pays. Insurance estimates are provided as a courtesy, however, are not a guarantee of coverage. In the event that your insurance carrier pays less than the estimated amount, then it is your responsibility to remit the full unpaid balance. Pre-determinations are performed upon request, however are not a guarantee of benefits. We accept cash, check, Visa, and MasterCard.

INSURANCE: We offer courtesy claims submission to dental insurance companies, however, please note that all charges for services rendered are ultimately the patient's responsibility. Your insurance policy is a contract between you, your employer, and the insurance company. Not all services are covered benefits in all dental contracts. Our team will do their best to assist you in the coordination of benefits, however, it is your responsibility, to review your policy, know your coverage and limitations, and keep track of your benefit status throughout your coverage year. We must emphasize that as dental care providers, our relationship is with you, not your insurance company.

CANCELLED OR MISSED APPOINTMENTS: Please kindly notify our office at least 48 hours in advance, so that we may accommodate other patients who wish to be seen. There is a $75 fee charged to those individuals who cancel or miss their appointment within 48 hours of their appointment time reserved. If you are late for an appointment, please understand your time reserved may be shortened or rescheduled.

CHECKS RETURNED AND NSF: There is a $40 charge for check returns and NSF per incident.

LATE PAYMENTS: Outstanding balances over 30 days are subject to a finance charge of 1% per month, 12% annual interest charge on your account.

PATIENT AUTHORIZATION: I have read, understand, and agree to the terms and conditions of this consent for care and financial agreement. I authorize this office to release information, relating to my dental care to my insurance company and authorize payment of benefits to be made to Bernard Pak, DDS, PS – DBA Kirkland Smiles Dental Care. I understand and agree that regardless of my insurance status, I am ultimately responsible for the cost of dental care provided to me by Kirkland Smiles Dental Care. I agree to pay all fees and charges for such treatment and services rendered. I understand as the parent and/or legal guardian of the minor receiving dental care at this office, I am ultimately responsible for all payments or fees for dental services rendered to the minor in my care. I agree that this authorization shall remain valid until canceled by me in writing.

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Patient Signature (Parent or Legal Guardian) Date

_____

Print Name (Parent or Legal Guardian) Date

_____

Witness / Reviewed By Date