Bernard S. Pak, DDS, PS
312 - 11th Ave West, Suite 101
Kirkland, WA 98033
425.893.9500
www.KirklandSmiles.com

FINANCIAL AGREEMENT

Patient Name:____ **Date:**____________________

GENERAL: 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 in no way a guarantee of coverage. In the event that your insurance carrier pays less than the estimated amount, then you, the patient and/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, check, MasterCard and Visa.

INSURANCE: Please remember that your insurance policy is a contract between you, your employer and insurance company. Not all services are covered benefits in all dental contracts. **It is your responsibility, as the patient, to review and know your policy, its coverage and limitations, as it is an agreement between you and your insurance company.** Our staff will do their best to assist you in coordination of benefits, however it is ultimately your responsibility to keep track of benefits and remaining benefits throughout the benefit year from your insurance. 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.

CANCELLED OR MISSED APPOINTMENTS: Please kindly give 48 hours advance notice if you cannot keep your appointment. There is a $65 fee that will be charged to your account for the time reserved for appointments missed or cancelled late without 48 hours advanced notice given. If you are late to an appointment, please understand that your appointment may be shortened or rescheduled.

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

FINANCE CHARGE: Outstanding balances over 30 days are subject to a 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 financial agreement. I agree to abide by the terms of these financial policy. 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 balance on my account.

I authorize and give consent for dental treatment of the patient named above and 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 cancelled by me in writing.

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Patient Signature (Parent or Legal Guardian) Date

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Print Name (Parent or Legal Guardian) Date

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Witness / Reviewed By Date