Robert W. McDowell, D.D.S., P.C.
365 Portland Avenue
Gladstone, OR 97027
503-655-4111

OFFICE POLICY

In order to assist you in making payment for your dental treatment, several options are available. We accept cash, check, debit and Visa, Master Card, American Express or Discover credit cards. If you are without dental insurance, payments made with cash, check, or debit at the *time of service* a 5% discount is available. Payments made by credit card are not available for the discount. **If your payment is not received in full after 60 days, a 1.5% interest fee will be applied to your remaining balance. After 90 days, a $10.00 monthly billing fee will also appear on your statement**. **Accounts turned over to a collection agency will receive a 35% final notice fee.** **PATIENT/RESPONSIBLE PARTY-INITIALS**____________

If financial arrangements are necessary, monthly payments are available to a maximum of 4 months. We are willing to extend this to you however; payments are required to be automatically charged to a credit or debit card each month on a day that you choose. Unless these specific payment arrangements have been made prior to treatment, your balance is *due at the time services are rendered*.

If you have dental insurance, as a courtesy, we will bill your insurance carrier directly. Insurance plans vary and we will do our best to obtain information to help assist you in maximizing your benefits to the fullest. However, please remember the *estimate* is not a guarantee of payment by your insurance carrier. The percentage of coverage by your policy may be based on the company's own reduced fee schedule. We have found that insurance plans rarely cover 100% of all services rendered; some routine and necessary dental services are not covered by all insurance carriers.

The appointment that you scheduled is reserved specifically for you, but if it becomes necessary to reschedule, we ask that you please phone a minimum of 24 hours in advance. Appointments changed without a minimum 24-hour notice may be subject to a broken appointment fee. Appointments exceeding 1 hour in length are asked to provide a minimum of 48 hours notice. We realize that your time is very important to you, so we make every effort to stay prompt and ask that in return we may receive the same consideration. **Missed appointments may be charged a minimum $50.00 fee.**

We reserve the right to charge a $25.00 fee for all checks returned for non-sufficient funds. If you wish to leave a credit balance on your account for future services, we require an authorization form signed. Any credit balance returned to you will be issued by check.

If you share our belief in quality dentistry, the best available, we will team with you to make it a part of your life. Any questions you may have concerning your treatment, financial arrangements or appointment, please do not hesitate to ask. We welcome open communication with our patients and wish to develop a relationship of trust and friendship.

______________________________ ______________________________

SIGNATURE **DATE**

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Policy for Acceptance of Dental Plans

For our office to accept assignment of benefits from your dental plan you must read this document and accept the guidelines and policies set forth.

1. **Your dental plan is a contract between you and your insurance carrier. We are not a party to that contract. It is your responsibility to understand your benefits as defined by your plan.**
2. You are responsible for payment of all charges incurred in this office. Some, if not all, of your treatment may not be covered by your dental plan. You are responsible for any finance charges on any outstanding balances. Future services, both dental and clerical may be refused until the balance is cleared.
3. **The custodial parent/guardian is ultimately responsible for the charges incurred at this office regardless of personal circumstances such as divorce or custody issues.**
4. We will not bill your dental plan unless you provide us with accurate information required by your plan in order to submit for a dental claim.
5. If your dental plan has not paid the assigned balance in full within 60 days from the date the charges were incurred, we require payment of your remaining balance.
6. **All estimated co-payments and deductibles are due in full at the time services are rendered.**
7. If necessary we will submit a claim for payment twice to your dental plan. However, if there is no resolution, it is the responsibility of the insured to contact their dental plan and seek payment. We will only provide further assistance once your balance is paid in full.
8. **We cannot accept assignment of benefits for college age student dependants 18 years of age and older. Please have student's school information available for claims processing.**

I have read the above and I understand and agree to abide by this policy. I authorize my insurance carrier to assign dental benefits to this office. I also authorize the release of any information necessary to process my dental claim.

Patient/Guardian Signature **Date**