Westford Family Dental

3631 Hoyt Ave, Everett, WA 98201 425.259.5188

We ask that you arrive at your scheduled appointment promptly and with photo ID, insurance card and insurance co-pay if applicable.

Financial Responsibility:

- The patient ultimately is responsible for all charges associated with their dental care regardless of insurance coverage. We try to make your dental care as cost efficient as possible.
- We ask for payment at the time of service. Financial arrangements must be established before our office can proceed with any recommended treatment.
- All patients who are seen in our office for a comprehensive exam are provided with a treatment plan. This is an **ESTIMATE** of the anticipated cost of your dental treatment. It will include an **ESTIMATED** insurance payment based on your plan's coverage. If your carrier's payment differs from our estimate, you are responsible for the balance. **Any claims over 90 days become your responsibility** and you will receive a Statement of Services. The balance is due and payable by the 25th of the month. In case of an overpayment, you are entitled to a prompt refund.
- **If no dental insurance, we offer 5% cash or check courtesy at the time of service.** We accept VISA, MasterCard, Discover, Care Credit, personal checks and cash as forms of payment.
- If you have any questions regarding your account or are experiencing circumstances beyond your control, please contact us. Our practice firmly believes that a good doctor/patient relationship is based upon a clear understanding of office policies and an open line of communication. We make every effort to clarify any possible disagreements over payment for professional services.
- Please be advised that in the case of your account becoming delinquent, we do utilize the services of an outside collection agency.

Late Cancellation and No Show Fee Policy:

- A late cancellation or no show fee of **$50** will be charged to all patients who do not provide **24 hour** notification to cancel a scheduled appointment or for patients who miss their scheduled appointment.

Treatment of a Minor (under the age of 18):

- If a patient is under the age of 18, a parent/guardian of the child **must be present** at the time of the new patient appointment. The parent/guardian is responsible for the patient's co-pay and referral needs or other insurance requirements at the time of service for all scheduled appointments.
- **Westford Family Dental must have** a signed consent form on file or a note signed by a parent/guardian if not accompanying a minor to future appointments.
- In cases of separation or divorce, the parent/guardian bringing the child is responsible for payment.

Consent to Discuss Dental Care:

- All legal aged patients (18 years or older) and parents/guardians of minor patients will be asked to complete a **Consent to Discuss Dental Care** form. Completion of this form provides authorization for staff to discuss dental care with those individuals listed.

Health Insurance Portability and Accountability Act: (HIPAA):

- I understand **Westford Family Dental** will use and disclose health information about me in compliance with the HIPAA Act. I understand I am entitled to receive a copy of the Notice of Privacy Practices as outlined by Federal Regulations. I have the right to ask that some of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices. I also understand **Westford Family Dental** is not required by law to agree to such requests. My signature below acknowledges I am aware of my rights in accordance to HIPAA.
- By signing this form, I acknowledge that I understand the policies as outlined above. In addition, my signature permits **Westford Family Dental** to file claims to my insurance (if applicable). I also understand I accept financial responsibility for all services rendered regardless of insurance coverage.

Our patients and our relationships with our patients are very important to us. If you have any questions, concerns, or need assistance, please contact us immediately.

Patient Name _____ Date _____

Signature of Patient, Parent/Guardian _____ Date _____