17694 1st Ave South, Suite B * Burien, WA * 98146

Office Guidelines

Our commitment is to provide the highest quality of dental care to our patients. In an effort to offer affordable services to all of our patients, we kindly request your adherence to our guidelines.

We will make every effort to provide you with an estimate of your care, prior to treatment. Treatment plans may change during procedures and you will be notified of any additional services and costs, if they should be recommended.

The patient or guardian of the patient is financially responsible for the total cost of dental care provided, regardless of insurance. As a condition of treatment by this office, I understand that payment is due at the time of service and any financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangement, must be paid for at the time services are performed.

Rescheduling an appointment: We request 48 hours, advance notice to reschedule or cancel an appointment. A $50.00 fee (per hour) will apply with less than 48 hours advance notice.

Minors: All minors, age 17 and under must be accompanied to any dental appointment by a parent or guardian, 18 or older. Dental treatment will not be provided if a minor arrives unaccompanied and cancellation fees may apply.

Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to **All About Dental** benefits accruing to me under my policy.
I have read the above the conditions and agree to their content. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. I understand it is my responsibility to provide this office of any change in my insurance plan or eligibility status.

Collections/Fees: I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, any fees incurred as a result of turning a delinquent account to collections, will be the responsibility of the account holder. I understand there is a $50 fee for returned checks. Finance charges will apply to any unpaid balance, after 60 days.

Release of records: We reserve the right to charge a reasonable processing fee for duplicating and transferring your records. Please allow 48-72 hours for processing.

My signature below indicates that I have reviewed and understand the above guidelines

Patient Name_____Signature_____Date__/__/__
Responsible Party Name_____ Signature_____Date__/__/__