**ASSOCIATE IMPLANT & FAMILY DENTISTRY**
DR. DARRYL CHEN, D.D.S.
2901 Meridian Street
Bellingham, WA 98225
Telephone: (360)671.7228--Fax (360)738.9973

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***Please read over the following office policies, initial where indicated and sign and date at the bottom. If you have any questions, please ask one of our staff.***

**Collection Cost and Reasonable Attorney's Fees:** Any account more than 60 days in error, will be subject to a 2.0% interest charge per month. If this account is not paid as agreed and the account is assigned to a third party collection agency, I agree to pay the actual amount of any collection fee not to exceed 50% of the amount assigned. If this account is not paid as agreed, and legal action commenced to collect the amount due, I agree that, in addition to other charges authorized herein, I will pay reasonable attorney fees. **_____ (Initial)**

**Authorization to Pay Benefits to Dentist:** I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me. **_____ (Initial)**

**No Show Appointments:** If no reasonable effort is made to contact the office 48 hours in advance to cancel an appointment, a $100 charge will be levied against the patient responsible. **_____ (Initial)**

**Insurance Payments:** As a courtesy service, we will file your insurance claim form and any necessary supporting documents that may be needed to ensure the speedy processing of your claim. We encourage our patients to follow up with their insurance claims if there are any problems, since insurance companies respond better to the subscriber, who pays the premiums, than the dental office, who is a third party.

We can only estimate your payment portion based on the information you/we have on your particular plan **_____ (Initial)**

Payment of your patient portion is due at the time of visit. If we are unable to verify your eligibility and benefit levels at the time of the appointment, we ask that you pay the entire amount of treatment at the time of the visit.

Insurance portion estimates are based on the information we have been given on your plan. If the actual insurance payment differs from the estimate, you are responsible for the difference. Even if a predetermination of benefits has been received, the final amount paid by your insurance company may change. This amount is due to our office once final insurance payment has been received. If the discrepancy is in your favor, we will refund the difference, or you may choose to carry a credit balance to be used towards any future appointment. **_____ (Initial)**

**Payment Options:**

1. **Cash-** Includes money orders and personal checks
2. **Any major credit cards-** We accept credit cards as payment for treatment to the extent your credit line permits.
3. **Care Credit-** Offers a separate line of credit to cover your entire family's health care needs.
    - A credit line can be established and approval usually takes less than 10 minutes
    - Care Credit has an interest fee option
    - There is no annual or membership fee
    - Monthly payments as low as 3% of the outstanding balance

We would be happy to work with you to plan the most appropriate arrangements for your budget. Financing your treatment will allow you to begin your treatment immediately and spreads the cost over a period of time.

*Signature*: _____ *Date:* _____