



WWW.SEATTLEJAWSURGERY.COM ✉
 600 BROADWAY SUITE 460 📍
 SEATTLE, WA 98122
 206-207-1525 📞
 206-207-1625 📠

Financial Policy

INSURED PATIENTS

Patients with insurance are asked to pay the deductible and estimated patient portion at the time of treatment. We are more than happy to file your insurance claim for you. Please keep in mind that the estimated portion is just that, an **estimate**. Filing insurance claims is a courtesy that we extend to our patients. We make every effort to follow up on unpaid insurance claims, however if we have not received payment after 60 days, we ask you to discuss your claim with your insurance company.

NON-INSURED PATIENTS

If you do not have dental insurance, we ask for payment in full at the time of service. If you feel that financial arrangements are necessary, you may discuss this with the front office staff **before** treatment is started.

USUAL AND CUSTOMARY RATE (UCR)

Our practice is committed to providing the best treatment possible for our patients. Our fees reflect the usual and customary rates for our area. Keep in mind that the rates paid by your insurance carrier are determined by the insurance carrier and your employer and, in some situations, have no bearing on the real usual and customary rates charged in the local area.

NO-SHOW AND CANCELLATION POLICY

Your visit has been reserved for you. If you are unable to keep your appointment, we require 48 hours notice for cancellation/re-scheduling. If 48 hours notice is not provided a late cancellation fee of \$100.00 will be applied to your account.

DIVORCES

Both partners are responsible for the debts incurred up to the date of the divorce decree. The parent who requests treatment for a child is responsible for the balance of services rendered for your child.

LATE AND FINANCE CHARGES

A finance charge will be imposed on those charges not paid in full within 90 days of the day treatment was rendered. The finance charge is a periodic rate of 1.5% per month (18% annually). The amount of the late charge will be as authorized under the laws of Washington, with a minimum charge of \$1.00.

EMERGENCIES

Should you experience a dental emergency during non-business hours, please call our office. The recorded phone message will provide an emergency contact number.

STATEMENT OF UNDERSTANDING

Patient Signature: _____

Date: _____

Signature: _____

Date: _____

Parent or Guardian if Patient is a Minor