Puget Sound Dental Clinic
2302 South Union Ave Ste A-1
Tacoma, WA 98405

AGREEMENT FOR SERVICES

1. **Insurance & Financial Policy**

Our goal in discussing financial arrangements relative to your dental needs includes:

- To inform you of treatment alternatives
- Their respective advantages and disadvantages
- The consequences and/or risks of limited delayed treatment and/or non-treatment

1. Professional services are rendered to the patient, and no to the insurance company. Thus, the insurance company is responsible to the patients, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company
2. Unfortunately, insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a predetermined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which your insurance agreement allows. However, this should not have control over what is in your bet interest as far as treatment is concerned.
3. For your convenience, we will estimate the portion of the fee that your insurance company will not cover. This is just an estimate. After your insurance benefits have been paid, you are responsible for any unpaid balance. We will ask you to bring with you at the time of treatment the estimated uncovered portion of the total fee.
4. It is not possible to know exactly what your insurance coverage will be prior to treatment, as treatment sometimes changes. We can predetermine your benefits with your insurance company; however, this delays treatment 4-6 weeks or longer, waiting for the insurance company to respond, which may not be in the best interest of your oral health.
5. A finance charge of 1% will be added to your bill if payment has not been received within 60 days. This will allow adequate time for you to ensure that your insurance benefits have been paid to your satisfaction.
6. Should collections become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and courts costs.

Payment Options:

Cash **Check** **CareCredit** **Visa & MasterCard**

I authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay an uncovered balance; I hereby authorize release to information for insurance purposes.
I authorize **Dr. Kevin Huynh** to release all information necessary to secure the payment of the benefits.
I understand that I have final responsibility for all charges including all penalties whether or not paid by my insurance(s).
I understand further that the office has following policies which I willingly accept:

2. **Cancellation of Appointments**

Please notify us 48 working hours (two business days) in advance if you cannot keep your appointment(s). If an appointment is cancelled with a prior notification of less than 48 working hours, we reserve the right to charge a $50.00 late fee for each missed or cancelled appointment. Showing up more than 12min late for an appointment is also considered a missed appointment and a $50.00 late fee will be charged. Moreover, we reserve the right to dismiss any patient who missed two appointments.

3. **Additional Fees**

There is a $25.00 fee for duplication of x-rays and a $19.00 fee for searching and handling records. For duplication of records the first 30 pages will be charged at the rate of 63 cents per page. Requests for duplication of x-rays and records should be made at least five days before delivery is required.

4. **Inappropriate Behaviors**

We reserve the right to dismiss any patient because of misconduct or failure to act in a way appropriate to our practice. Such misconduct includes coming to an appointment when under the influence of alcohol or drugs, or using profanity in the office. Although only a small number of our patients violate these policies, we should nevertheless like all of our patients to be aware that these are our policies and that they should be adhered to.

We welcome you to our practice and hope that these policies will be acceptable to you.

Parent/Guardian name (if patient is minor)____**(mother/father/guardian)**

Signature:____**Date:**_______________________________