Issaquah Valley Dental Care
1660 NW Gilman Blvd, STE C1
Issaquah, WA 98027
Phone: 425-392-4122

Patient Consent - Office Policy

Patient e-mail address:_____

Our practice offers patients the opportunity to communicate with clinicians by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before giving consent. .

PATIENT ACKNOWLEDGMENT AND AGREEMENT
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the policy that Provider may communicate with patients by e-mail. Any questions I may have had were answered.

THE FINANCIAL POLICY

GENERAL

Thank you for choosing our practice as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read, and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor. FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD and CARE CREDIT.

REGARDING INSURANCE

Fees are estimates only, are valid for 30 days from the date shown above and are subject to revision. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER

All ESTIMATED portion and deductibles are due prior to treatment. In the event that YOUR insurance coverage changes to a plan where we are non-participating providers, refer to above paragraph.

USUAL AND CUSTOMARY RATES

Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved; Visa/MasterCard, or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS

Unless canceled, at least 2 business days (Monday-Thursday) in advance, our policy is to charge for missed appointments at the rate of $50.00 to the full amount of the scheduled visit. Please help us serve you better by keeping scheduled appointments.

INTEREST

We reserve the right to charge interest in the amount of 18% per annum as provided by state law. Thank you for understanding the Financial Policy.

CONSENT

I understand and agree to this Financial Policy.

SIGNATURE ON FILE

I hereby authorize payment directly to the dental practice listed above of the dental benefits otherwise payable to me.
I understand my signature is valid for two years from the above date, unless revoked by me at an earlier date.

The above listed dental practice and its staff is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, which ever is shorter.

I know I have a right to receive a copy of this authorization upon request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify)_____.

_____

Comments:

_____