South Waterfront Dental, LLC
Todd L. Beck, DMD
3671 SW River Parkway
Portland OR 97239
503-841-5658

FINANCIAL POLICY **ACKNOWLEDGEMENT**

We are committed to providing you with the best possible care. Our fees reflect our professional commitment to excellence. As the responsible party, this agreement is to inform you of your financial obligation to our practice. This financial agreement is intended to facilitate excellent service to you and your family while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and the insurance company. Our office is not party to that contract.

For the convenience of our patients we offer the following methods of payment of fees.

- Payment in full by cash, bank card or alternate financing of each appointment as service is rendered. Alternate financing (payment plans) must be arranged **before** treatment is rendered.
- For insurance patients, we will accept payment directly from the insurance company only for that percentage the company will cover and do require that the deductible and non-covered fees be paid at each visit. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments.
- Bank charge cards – Visa, Mastercard, Discover and debit cards are accepted.

We will gladly discuss your proposed treatment and answer any questions you might have as to the involvement of your benefit program in receiving this care.

There is no interest or finance charge on current accounts. After 90days, all accounts are subject to a finance charge of 1.5% a month, which is an annual percentage rate of 18%.

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Please sign and return to front desk

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

Signature:_____ Date:_____