PATRICIA CONN, DDS
COMPREHENSIVE DENTISTRY

2372 Main Street Ferndale, WA 98248
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OFFICE FINANCIAL POLICIES

Financial Arrangements

Dental health is a valuable investment in your overall health. We strive to work together with you to provide you with a treatment plan that meets your healthcare needs and fits your budget. We accept the following payment types:

- Cash or Check (a **5% discount** will be offered to patients without insurance if payment in full is made at the time of service).
- Visa, MasterCard, and Discover Credit/Debit cards are accepted (no discount is available for these methods of payment).
- CareCredit cards may be used for balances over $200.00. Additional information and applications are available online.
- Payments may also be made with credit or debit cards online at www.patriciaconndds.com. (Please keep in mind that this function is only available on desktop computers and is not supported on mobile devices.)
- All of your expected portion of treatment costs will be due at the time of service.
- A fee of $25.00 will be charged for all NSF/returned checks.

Outstanding Balances

Regular monthly statements are mailed for any outstanding balances. Finance charges are assessed on all accounts over 90 days past due at 1.5% per month (18% annually with a $1.00 minimum charge). Any patients with balances that are sent to collections will automatically be dismissed from this practice.

Dental Insurance

Dental insurance does **not** cover 100% of dental treatment fees. Our goal is to help you to maximize your benefits; however you are ultimately responsible for understanding the requirements and limitations of your insurance plan, as well as the payment of all fees on your account. As a courtesy to you, we will bill insurance on your behalf if you provide us with the necessary insurance information to do so. **Any quoted insurance benefits are an estimate only, and do not guarantee payment.**

Appointment Cancellations

We require **48 business hours notice** for any appointment changes or cancellations. A $75.00 fee will be charged for all appointments changed or cancelled without adequate notice. Three appointment changes or cancellations without adequate notice will result in dismissal from the practice.

I, _____, hereby certify that I have read and understand the previous information. I authorize Dr. Patricia Conn to release any information, including the diagnosis and records of treatment or examination, for my self and my dependents to insurance carriers and/or healthcare practitioners and dental specialists. I authorize the payment from my insurance carrier to be applied directly to any outstanding balance on my account.

Signature: _____ Date: _____