DOW DENTAL
FINANCE POLICY and PAYMENT AGREEMENT

1. **Policy**. You will be charged once each time you receive care. The total amount owing for treatment received is due and payable in full when treatment is rendered. If you have a remaining balance after we receive payment from your insurance company, you will be billed for it. Statements for any remaining balance are mailed on the 25th of each month, with the remaining balance due on the 15th of the following month. If we both agree that you will pay for a service in installments, you must apply for and pay using Care Credit.

2. **Estimated Amount**. See your treatment plan for the estimated amount paid by your insurance (if applicable) and the estimated remaining balance.

3. **Additional Charges**. If, prior to paying in full any remaining balance, you incur additional charges, you will pay the new charges as explained above.

4. **Late Payments**. A finance charge of 1.5% (18% annually) will be imposed on your account when any payment is 90 past due. Additionally, the entire balance may be sent to a collection agency and may result in denial of further treatment by us.

5. **Co-payments**. Any co-payments required by an insurance company, deductibles, co-insurance, and/or non-covered services must be paid at the time of service.

6. **Method of Payment**. We accept payment by cash, check, or credit card.

7. **Necessary Services**. You consent to the use of any necessary services the dentist and his or her clinical team determines is necessary to enable complete diagnosis and treatment, including x-rays, photos, or study models.

8. **Minor Patients**. The parent, guardian, or other accompanying adult of a minor patient is responsible for payment in full at the time of service. For unaccompanied minors, non-emergent treatment will be denied unless charges have been preauthorized or payment is made at the time of service.

9. **Cancelled Appointments**. Except in case of illness or other extenuating circumstances, we require 24 hours notice to cancel or reschedule any appointment. If you do not show for an appointment without providing adequate notice, you will be charged $100 for your scheduled appointment.

10. **Discounts**. We will only extend discounts based on prompt payments (i.e., cash discounts). Cash discounts will not exceed 5% of the balance due.

11. **Returned Checks**. A fee (currently $35) will be charged for any checks returned by the bank for insufficient funds. ORS 30.701.

12. **Insurance**. Insurance is a contract between you and your insurance company, and we cannot accept the responsibility of collecting your insurance claims or negotiating a settlement on a disputed claim as you are ultimately responsible for your account. As a courtesy to our patients with insurance, we will complete and submit your insurance claim for you. You authorize your insurance to pay to us, and hereby assign directly to us, all benefits payable with respect to services we provide. You are responsible for obtaining any required referrals for treatment prior to your appointment. You will be financially responsible for charges due to the lack of a required referral. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of our charges not covered by insurance.

13. **Worker's Compensation**. We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

14. **Attorney Fees**. In the event we are required to consult an attorney or commence any legal proceeding for the purpose of interpreting or enforcing any provision of this agreement or to collect any indebtedness owing pursuant to this agreement, we shall be entitled to recover reasonable attorney fees in such proceeding, or any appeal thereof, in addition to the costs and disbursements allowed by law. You will be entitled to recover your reasonable attorney fees from us should you prevail. The amount of the fee shall include an amount estimated by the court as the reasonable costs and fees to be incurred by the prevailing party in collecting any monetary judgment or award or otherwise enforcing any order, judgment, or decree entered in such suit or action.

15. **Notice to Patient/Debtor**. DO NOT SIGN THIS AGREEMENT BEFORE YOU READ IT. YOU ARE ENTITLED TO A COPY OF THE AGREEMENT YOU SIGN. KEEP THIS AGREEMENT TO PROTECT YOUR LEGAL RIGHTS.

Date

You

Patient's Name (if different)