ROBERT E. TRACY D.D.S., P.S.
206.362.3833

FINANCIAL POLICY

Our office goal is to provide you with the highest quality comprehensive dental care plan, followed by a preventative maintenance schedule. We strive to present all treatment and financial information prior to all restorative appointments, therefore eliminating all lingering questions. To keep our services comfortably affordable, we are pleased to offer you the following options for payment. Please note **payment in full is expected at time of service.**

1. If you have insurance, we will gladly process your claim as a service to you at no charge.
2. A 5% courtesy discount for payment in full with cash or check.
3. We accept Visa, MasterCard, AMEX and Discover.
4. We offer extended financial arrangements up to a maximum of 90 days interest free. For this option, **an auto-pay credit card authorization must be on file.**

Insurance: We are happy to assist you in obtaining maximum dental benefits by preparing and submitting your claims. Please note that our fees are not based upon any insurance schedules, and may be above insurance allowances. In addition, **any estimate that we provide to you is only an estimate; you are responsible for all fees in their entirety**. There are some plans in which we do not participate as a preferred provider. **We require payment of deductibles and coinsurance to be paid at the time of service.** If your insurance carrier disputes payments, they will become the full responsibility of the patient after 90 days from the date of service. We cannot be responsible for collecting your insurance benefits or negotiating a settlement of a disputed claim, although we will do our best to assist you during the process.

Finance Charges: **Account balances over 90 days from the date of service are subject to a 1.5% monthly finance charge as well as a $25.00 billing fee.**

Appointment Reminders: As a courtesy, we routinely call to remind patients of their appointments a day in advance. However, we do expect our patients to be responsible for keeping their appointments whether or not a reminder call was received. Your appointment time is reserved exclusively for you and we appreciate your commitment to keep it. **We do understand that at times an appointment must be changed, but require 48 business hours notice to avoid a $50.00 per scheduled hour cancellation fee.**

I have read, understand and accept the information presented above.

Signature Printed Name Date

Insurance Assignment and Release:

I, the undersigned, have dental insurance, and assign directly to Robert E. Tracy D.D.S. all dental benefits, payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature Printed Name Date