*South Sound Dental Care*
*2115 S. 56th Street Suite 202*
*Tacoma, Wa 98409*
*Ph. 253-473-4303 Fax. 253-473-0201* *Dr. Moona Khan, DDS*

# FINANCIAL POLICY

**PAYMENT TYPE OPTIONS**

Our mission is to deliver gentle dentistry through the finest and most cost effective healthcare treatment available today. Following your diagnoses the doctor will advise you of our intended plan for treatment. Additionally, we will discuss with you the cost of your treatment and future treatments.

Payment for your dental treatment is due at the time of service. We understand that some patients may not be able to (or may not desire to) pay cash for their treatment. Therefore, we offer several different payment types for your convenience to pay for your treatment:

1) Cash or Check
2) Visa, MasterCard and American Express
3) CareCredit or CitiCards financing (if approved) –If interested, please ask for an application.

**MISSED APPOINTMENT FEES, INTEREST & LATE CHARGES, NSF CHECK FEES**

**I acknowledge that a $50 charge will be assessed for each hour of a missed appointment not cancelled at least 24 hours in advance.** I also acknowledge that a late charge of 1.0% per month, at a rate of 12% per year, with a minimum charge of $1.00 per month, will be charged on all unpaid account balances that are 30 days past due. I also acknowledge that a $25 charge will be assessed for an "NSF" checks (i.e., checks not paid by my back due to non-sufficient funds or for "stop payment"). I realize that failure to keep my account current in payment will result in this office being unable to provide me additional dental services. In the case of this account being sent to a collection agency for a past due balance, I agree to pay all collection agency costs, reasonable attorney's fees, and legal expenses incurred to collect such past due balance.

**AUTHORIZATION, RELEASE, AND ACKNOWLEDGEMENT OF FINANCIAL POLICY**

1. I authorize your office to release any information related to my dental treatment, including any diagnosis and records or x-rays of any treatment or examination rendered to me during the period of such dental care, to any third party payors, insurance companies, and/or other health and dental practitioners.

2. I authorize and request my insurance company, if any; to pay directly to your office the insurance benefits otherwise payable to me. I understand that your office is providing a courtesy to me by allowing me to assign my insurance benefits to your dental office, and that your office may terminate this courtesy at any time.

3. I understand that my dental insurance company and/or my primary responsible party may pay less than the actual bill for services. I agree to be solely responsible for full payment of all services rendered on my behalf or on behalf of my dependents should for any reason my insurance company and/or my primary responsible party fail to pay or pay less than full for such services.

I acknowledge that I have reviewed your office's Financial Policy.

X_____ _____
Signature of Patient (or Signature of Parent/Guardian if a minor patient) Date

THANK YOU for filling out this form completely and reviewing our above office policies. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.