Appointment Agreement

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your appointment time. If you must change an appointment, please provide us at least 2 business days in advanced notification so that we may use our time to accommodate other patients and avoid a broken appointment fee. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

Financial Agreement

Unless another financial is PRE-ARRANGED, payment in full is due the day of treatment. Should a patient have dental insurance with assignment to Bellevue Dental Care, the estimated patient portion will be the amount due. Insurance payments without assignment will be sent to the insured with payment due in full.

Payment options:

1. For your convenience we accept Cash, Check, Visa, MasterCard, Amex, and Discover cards.
2. We also offer short and long term financing options through our financial partner Care Credit.

For patients with Dental Insurance:

Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take are of all costs. Your dental benefits and how they relate to your specific needs will be explained to you during the Treatment Discussion appointment.

Finance Charge and Fees:

- Balances in excess of 90 days are subject to a finance charge of 1.5% per month (18%annual)
- Return checks are subject to a $25.00 accounting fee

Authorization and Consent

General Consent to Treatment:

I agree and consent to a dental examination by Bellevue Dental Care. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatment performed.

Release of Information:

I authorize Bellevue Dental Care to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other health professionals.

- I understand and will comply with office Appointment Agreement.
- I understand and will comply with the office Financial Agreement.
- I understand and agree to the General Consent to Treatment.
- I authorize the Release of Information.

Patient/Guardian signature: _____ Date:_____