**LAKE FAMILY DENTAL**

**721 Country Club Road Eugene, OR 97401**

**(541) 686-1199**

**FINANCIAL OPTIONS**

*Our commitment is to provide quality dental care to the entire family through exceptional service and the utilization of advanced technology.*

**METHODS OF PAYMENT**

* Cash or Check
* Credit Card (Discover, Master card, Visa, American Express, and Care Credit)
* Dental Insurance (described below)

**DENTAL INSURANCE**

* We are pleased you have dental insurance, and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer and the insurance company. **We will need you to bring us a copy of your benefit booklet if you would like help interpreting your benefits.**
* As a courtesy to you, we will file your insurance and accept assignment of benefits if you have signed the insurance payment authorization form. We ask that your estimated co-payment and deductible be paid at the time of service.
* Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover.

**RELATED INFORMATION**

* An additional fee of $35.00 will be applied to the unpaid balance at the end of the month for returned checks.
* In the event that the account is not paid and we refer the account to collections, you will be responsible for **all** fees incurred for collection of your bill (i.e., attorney fees, court costs, and collection agency fees).
* Your appointment time has been reserved exclusively for you, any change in your appointment affects many patients.
* A missed appointment is an appointment for which a patient fails to show up, OR does not give **48 hours** advanced notice. (PLEASE NOTE 48 HOURS IS 2 WORKING BUSINESS DAYS FOR OUR OFFICE, PLEASE KEEP IN MIND WE ARE NOT OPEN FRIDAY, SATURDAY, OR SUNDAY.)
* There will be a **$25** charge for a **second** missed appointment which must be paid prior to rescheduling. In the event of a **third** missed appointment, an additional **$50** fee will be charged as well as a **$100 deposit** being required to schedule any future appointments. Patients with a history of missed appointments may be subject to dismissal from the practice.

**I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.**

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 Signature Date