BETHANY DENTAL CARE FINANCIAL AGREEMENT

15280 NW Central Drive Suite 201 Portland, OR 97229
503-533-8240

Our Primary Mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS:

Patients without insurance

- VISA, MasterCard, American Express or Discover, Health Savings Accounts
- We offer a 3% discount for those patients paying with cash or check. Returned checks will have an additional $50.00 charge.
- Seniors age 65 and older with no insurance will receive a 10% discount, when paying by cash, check or card.
- Patient portions are due at the time of service.
- Any balance not paid within 60 days will be charged a service fee of 18% per annum.

Patients with Insurance

As a courtesy, we are happy to work with your insurance carrier to maximize your benefits, and directly bill them for reimbursement of your treatment. Your patient portion may be paid for by any of the above payment options.

PAYMENT PLANS

Care Credit, Springstone Patient Financing

- Monthly payments: No interest payments for 6 months, 12 months or 18 months.
  No annual fees or pre-payment fees
- SAVE 5% with our pre-payment policy.
  You may pay in advance for the scheduled services and save 5% on the patient portion.

Appointment Policy:

When you have reserved an appointment with Dr. Enayati, we will call to confirm your appointment 24 hours prior to your appointment. We require a returned call to confirm that you will be keeping your appointment. We will be contacting you by phone or email.

- Re-Scheduling: Appointments must be changed 24 hours in advance.
- Missed appointment policy: If two consecutive appointments are missed or rescheduled, we will require prepayment for all future appointments.
- Cancellations: Must be cancelled 24 hours in advance or there will be a $60.00 fee.
- No Show: A $60.00 fee will be charged.

Treatment plans diagnosed and presented to you are an estimate only. Due to unforeseen changes to your dental health or changes in insurance fee schedules and limitations, this may result in adjusted treatment plans and fees.

I agree to this financial policy presented to me on _____ . I agree to pay any collection costs involved should my account be submitted to a collection service.

Patient (parent or guardian) Signature **Print** **Date**