Factoria Family Dentistry

4100 Factoria Blvd, S.E. #D • Bellevue, WA 98006 • (425) 747-8888

Patient name: _____ DOB: _____

Spouse/Parent/ Person responsible for this account: _____

PRIMARY DENTAL INSURANCE

Ins. Co: _____

Group #: _____

ID#_____

Phone #: _____

Name of Insured: _____

Relationship to patient: _____

SS#: _____DOB: _____

Employer: _____Phone: _____

SECONDARY DENTAL INSURANCE

Ins. Co: _____

Group #: _____

ID#_____

Phone #: _____

Name of Insured: _____

Relationship to patient: _____

SS#: _____DOB: _____

Employer: _____Phone: _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services or any dental services performed without previous financial arrangements;
Must be paid for in cash at the time services are performed.

Patients, who carry dental insurance, understand that all dental services furnished are charged directly to the patient and /or he/she is personally responsible for payment of all dental services.
This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account.

However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company

A service charge of 12% annual on the unpaid balance will be charged on all accounts exceeding 90 days,
Unless, previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay heretofore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me in writing, within the time of payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and
I further agree to pay all costs and reasonable attorney fees if a suit shall be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____Date: _____ Relationship to patient: _____

Signature of patient, parent, or person responsible for payment.