DAVID TO, DMD
1432 NE 151st Street
Shoreline, WA 98155
(206) 362-2273

FINANCIAL POLICY

Thank you for entrusting our office to help you achieve your oral health goals. Dr. To and his staff are committed to making your visit to the dentist an educational and positive experience, and we take pride in the quality of dentistry provided and it's important to us the quality of our business services is parallel. Our office policies provide transparency to help you achieve your oral health goals with consideration of your time and budget.

_____(int) Payment is required at the time of service. We accept cash, personal checks, and all major credit cards. Finances should not be an obstacle in receiving care, and we will make every effort to work within your budget. In the event you are unable to pay in full at the time of service, we will work with you to determine a financial arrangement that reasonably works for you and the office prior to scheduling treatment.

_____(int) We will file and apply insurance benefits as a courtesy for our insured patients. We accept most major dental insurance companies and are happy to submit claims on behalf of our patients. Treatment estimates are meticulously put together although there is no guarantee of payment from your insurance company. We will make every effort to utilize and maximize your dental benefits. However it is impossible to determine the actual insurance benefit for any service. **All unpaid insurance balances are the responsibility of the patient (or responsible party) and are due within 60 days from the date of service.**

_____(int) Missed appointments and late cancellations present a problem for us both. For you they cause a delay in recommended treatment and care. For us, they prevent another patient in need of treatment from being scheduled. In the event you need to cancel your appointment, we require 48 business hours advance notice. No shows and cancellations without 48 hours notice will be subject to a broken appointment fee of $50 per 30 minutes missed. We understand there are emergent situations that may prevent you from providing adequate notice. These situations will be considered on a case-by-case basis.

Your signature below acknowledges that you have read and understand our policies. Please let us know if you have any questions.

_____

Patient Signature (Legal Guardian) Date

_____

Patient Name (Printed)

OFFICE USE ONLY
PATIENT CHART #: