Family Dental Care of Bellevue – Financial Policy
Hilarie Galloway, DMD & Jennifer Wilson, DMD
4100 Factoria Blvd SE, Suite A
Bellevue, WA 98006
425-643-5778

Patient name:_____

INSURANCE INFORMATION

Subscriber name: _____

Your Relationship to Subscriber: Self_____ Spouse:_____ Child:_____ Other:_____

Subscriber DOB: _____ Patient DOB:_____

Subscriber SSN or ID#: _____

Insurance Company Name: _____ Insurance Company Phone Number:_____

Insurance Company Address:_____

--DO YOU HAVE ANY ADDITIONAL INSURANCE? IF YES, COMPLETE THE FOLLOWING-

Subscriber name: _____

Your Relationship to Subscriber: Self_____ Spouse:_____ Child:_____

Subscriber DOB: _____ Patient DOB:_____

Subscriber SSN or ID#: _____

Insurance Company Name: _____ Insurance Company Phone Number:_____

Insurance Company Address:_____

Treatment is not rendered based on the assumption that your insurance company will pay. The responsible party signed below must pay whatever part of the account balance not paid directly to the practice by an insurance company. Should your coverage change or lapse during the course of treatment, any expected amounts left unpaid by the insurance company would become your responsibility. Please keep in mind that this financial agreement is with you and not your insurance company. We require payment of your expected out of pocket for treatment rendered, to be paid at time of service.

MISSED, CANCELLED OR RESCHEDULED APPOINTMENT POLICY

There will be a fee of $100 per appointed hour, applied for any missed appointment or to cancel or reschedule an appointment without 24 business hour notice.

CONSENT FOR TREATMENT AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby grant authority to Family Dental Care of Bellevue and/or staff in charge of the patient, whose name appears on this form, to administer any treatment which may be deemed necessary or advisable. I hereby authorize payment of any insurance benefit, that otherwise would go to me, go directly to Family Dental Care of Bellevue. I understand that I am responsible for payment of dental services provided in this office for myself/dependents. I understand all outstanding balances over 90 days shall accrue interest at a rate of 1.5% per month.

Signature_____ Date _____