CASCADE

DENTAL CARE

Financial Agreement

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment.

As your dental care provider, our relationship is with you, our patient, not with your insurance company. We will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance.

We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company at time of service.

If Insurance is not applicable, payment is also due at time of service.

We accept all forms of payment as well as financing with no interest options.

I confirm that I have read, understand, and agree to the above Financial Agreement. I hereby authorize payment of insurance directly to the dentist or dental group. I understand that I am financially responsible for payment for any patient portion.

Signature of Patient/Legal Guardian: _____

Date: _____

1425 Wakarusa Dr., Ste A Lawrence, KS 66049
Phone: 785-841-3311/Fax: 785-843-0421
Email: cascadedentalks@gmail.com
Web: cascadedentaldds.com