kenner dental group
COSMETIC AND RESTORATIVE DENTISTRY

1800 SW 152nd Street, Ste 201, Burien, WA 98166 | (206) 248-1339 | www.kennerdentalgroup.com

# Financial Agreement

Kenner Dental Group is committed to providing you with the best dental health care available. We have found that a clear understanding of our office financial policies relieve some of the anxiety associated with going to the dentist. We want to be certain that our policies are clear and that all of your questions are answered to your satisfaction. For your convenience we offer several different payment plans. We accept Cash, Check, Visa, MasterCard, American Express and Care Credit. Please inform us prior to your appointment if a payment arrangement is needed.

**Patients with Dental Insurance**

As a courtesy, our office will check your benefits and send in proper claims for reimbursement. We will make a Good Faith estimate for planned treatment and request that you pay your estimated portion at the time of service. We will make every effort to provide you with an accurate estimate based on what the insurance company discloses to us. However, we can only provide you with an estimate of coverage and final payment is determined by your insurance company. Your insurance may not pay as much as estimated or may refuse payment for certain procedures based on your policy provisions. Fee schedules, waiting periods, alternate benefits, downgrades and other clauses/exclusions will also affect your coverage. You will be responsible for any amount not covered by your insurance plan.

**Appointment/Cancellation Policy**

We respect your time and ask that you respect ours by honoring your appointment commitment. A broken appointment is a loss to everyone. Since your appointment is specifically reserved for you, we do charge a fee of $75 for any appointment that is rescheduled or cancelled without the proper two business days' notice (Mon-Fri).

I authorize payment to be made to Kenner Dental Group by my insurance company and I accept financial responsibility for all services not covered by my insurance. I hereby agree that in the event of default of any amount due on my account, and if the account is placed with a collection agency or for legal action, I the debtor agrees to pay all collections costs including any associated legal fees in addition to the original amount owed on my account. I have read the above conditions and have had the opportunity to have my questions answered. I understand by signing this document , I agree to all terms contained within it.

| ______________________________ | ______________________________ |
|---|---|
| Patient Name | Patient Signature |

______________________________

Date