

**Totem Lake Dentistry for Children and Adults  
Greg S. Nash, D.D.S.**

**Office Policy Acknowledgment**

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. For the convenience of our patients, we offer the following payment options and office policies.

**PAYMENT OPTIONS:**

Payment in full by cash, check, Visa, MasterCard or alternate financing for each appointment that services are rendered.

Care Credit: alternate financing for your healthcare needs. No payment down, low monthly payments, interest free options and no cost to apply.

Insured patients: as a courtesy to you, we will be happy to file all necessary forms needed. Payment is due at the time of service for what the insurance is not expected to pay including all co-payments and deductibles. For major services such as crowns, bridges and dentures, % of your portion is due at initial visit and remaining% due at completion unless prior arrangements are made.

Your dental benefit is a contract between you, your employer and the insurance company; we are not a party to that contract.

Our fees generally, but not necessarily, fall within the usual and customary fee structure determined by your carrier.

Not all dental services are a covered benefits, please check your plan.

We estimate your portion at the time of service. You are directly responsible for all services rendered, regardless of any partial insurance payments.

**OFFICE POLICIES**

Finance charges apply (1.5% per month) for all balances that exceed 60 days. A \$10.00 billing charge will apply monthly to accounts over 90 days

As a courtesy for other patients, the doctor and our staff { please allow a 48-hour notice for all cancelled or rescheduled appointments. A charge may apply for missed appointments.

I have read and understand the above office and financial policy. I authorize Dr. Nash to furnish information to insurance carriers concerning my treatment or that of my dependent. I hereby assign to Dr. Nash all payment for dental services rendered.

\_\_\_\_\_  
Patient or responsible party

\_\_\_\_\_  
Date