OFFICE FINANCIAL POLICY

Michelle Graber DMD
Graber Dental
18425 SW Alexander Street
Aloha, Oregon 97006
Tel 503-259-8641

In our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment.

- 5% accounting courtesy is offered when services of $500. or more are paid in full with cash or check at time of treatment.
- Visa, Mastercard, Debit Card
- Care Credit Payment Plan

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solution possible to treat your personal situation.

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within sixty (60) days of date of service, regardless of whether or not my insurance benefits have been received. One and a half percent (1.5%) per month interest, eighteen percent (18%) per year will be charged on accounts 60 days from treatment date. I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data. I also understand that all delinquent accounts will be assigned to a collection agency.

There will be a $50 minimum charge for all appointments missed without a 48-hour notice. We will not reschedule any patient after two missed or rescheduled appointments. Our time is valuable and must be used efficiently to keep our expenses at a minimum and our fees within reasonable limits.

For all returned checks there will be a fee charged of $25.00.

If you have any questions regarding this policy, or if you would like a copy, please ask.

Signature_____ Date_____