KIRKLAND DENTISTRY
FAMILY & COSMETIC
DAVID RICHARDSON DDS

We are committed to providing you with exceptional state-of-the-art dentistry based on your individual needs. To assist you in receiving this care, we offer the following terms:

Financial Policy

- Payment is due at time of service and may include cash, check, FSA, HSA, Visa, MasterCard, or Discover debit/credit.
- Special payment arrangements may be made upon approval from Kirkland Dentistry. In-house payment plans are available for up to 3 months with 50% down at time of service and with a credit card on file.

We accept many insurances. We are preferred providers for Washington Dental Service, Delta Dental, Cigna, Premera, MetLife, Regence, Guardian, Connection Dental, Dentemax, and Aetna. Payment of your co-insurance and/or co-pay is due at the time of service. *Your out-of-pocket amount is an estimate only. Regardless of insurance coverage you are responsible for all fees.* X_____

We are happy to file the forms necessary to see that your insurance pays their portion to our office. However, if the outstanding insurance amount due is not received within 30 days, you will be responsible for the balance due at that time. Any payment from your insurance that results in a credit on your Kirkland Dentistry account will be refunded to you promptly.

Cancellation Policy

We understand that your time is valuable and we do our best to stay on schedule. In order to achieve this goal, please provide ONE BUSINESS DAY'S (Monday through Friday) notice for any appointment changes or cancellation. For any no-show or late cancellation, you agree to pay $75.00. X_____

Patient Agreement

With your signature, you acknowledge:

- The fee for your dental treatment is your responsibility and you will assist Kirkland Dentistry in receiving payment from your insurance in a timely fashion.
- If your account should become delinquent (30 days past service), you may be subject to additional collection charges and fees.
- Payment communications may be sent to you through your email address on file with Kirkland Dentistry.

By signing this agreement, you agree to abide by these terms and conditions.

Responsible Party signature_____ Date _____

Print Name _____

Patient, if different from Responsible Party _____
(Please print)