DEFELICE HOLISTIC FAMILY DENTISTRY

4703 N. Maple Street
Spokane, WA 99205
(509) 327-7719 Fax (509) 3277110

Armand V. DeFelice, DDS
Loretta A. Rosier, DDS
Louise C. DeFelice, DDS

FINANCIAL POLICY

Welcome! We are happy you have chosen us to provide health-centered dental care for you and your family. We appreciate the opportunity to work with you. It is our intention to provide you with the finest care possible while ensuring that you fully understand procedures, treatment and payment expectations.

REGARDING YOUR DENTAL INSURANCE: We are committed to help you receive the benefits you have paid for and that your particular dental insurance allows. We will be happy to discuss your proposed treatment and answer any questions that you may have. As a courtesy to you, we will submit our charges to your insurance company for you. **PLEASE BE AWARE THAT IN MOST CASES, THE INSURANCE WILL COVER ONLY A PORTION OF THE FEE AND THAT YOU ARE FINANCIALLY RESPONSIBLE FOR ANY AMOUNTS NOT COVERED.**

Payment is expected at time of service regardless of insurance. Please circle your method of payment.

Cash **Check** **(5% saving is offered for cash or check payment at time of service)**

Visa **MasterCard** **Account number:_____________________ exp:_______**

Credit is extended only to established patients and on approved credit only.
Please let us know if you have any concerns or questions. We are happy to help.

AUTHORIZATION…

I authorize the Doctor to perform all forms of treatment, medication and therapy that may be indicated for my dental treatment. I understand that no expressed warranties or guarantees of any kind are made concerning results of procedure or treatment.

I certify that I am covered by insurance and assign directly to ***Armand V. DeFelice, DDS, Loretta A. DeFelice-Rosier DDS, and/ or Louise C. Guthrie, DDS*** *all insurance benefits, if any, and otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.*

I understand that where appropriate, credit bureau reports may be obtained.

I understand that all fees must be paid in full within 90 days of treatment regardless of insurance, unless other arrangements have been made (O.A.C. only). All overdue accounts and approved budget plans are subject to Finance charges (18%) on balances over 60 days.

I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature_______________________________________ Date__________________

There is a $25 charge for all canceled or broken appointments not given 24 hours notice.