Puget Sound Dental Clinic
2302 South Union Avenue, Suite A-1
Tacoma, WA 98405
Phone: 253-627-2648

AGREEMENT FOR SERVICES

I authorize my insurance company(s) to pay to Dr. Kevin Huynh all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Dr. Kevin Huynh to release all information necessary to secure the payment of the benefits.

I understand that I have final responsibility for all charges including all penalties whether or not paid by my insurance(s).

I understand further that the office has following policies which I willingly accept:

1 PAYMENTS FOR SERVICES

Payments and co-payments are due in full at the time services are rendered unless prior arrangements have been approved. We will try out best to resolve any disputes about financial charges. All balances are due upon receipt of bill. Interest will accrue at the rate of 1% a month on all balance not paid within 45 days of services rendered. If a patient refuses to pay a balance, we reserve the right to notify our collection agency that the balance is unpaid.

2 CANCELLATION OF APPOINTMENTS

Please notify us 48 working hours (2 business days) in advance if you cannot keep your appointment(s). If an appointment is cancelled with a prior notification of less than 48 working hours, we reserve the right to charge a $50.00 late fee for each missed or cancelled appointment. Showing up more than 15 minutes late for an appointment is also considered a missed appointment and a $50.00 late fee will be charged. If a patient had 2 consecutive no shows or short notice(less than 2 business days) cancellations within 6 months we reserve the right not to schedule for 3 months, or dismiss patient from our practice.

3 ADDITIONAL FEES

There is a $25.00 fee for duplication of x-rays and a $19.00 fee for searching and handling records. For duplication of records the first 30 pages will be charged at the rate of 63 cents per page. Requests for duplication of x-rays and records should be made at least five days before delivery is required.

There is a $25.00 fee for bounced checks, returned checks due to insufficient fund.

4 INAPPROPRIATE BEHAVIORS

We reserve the right to dismiss any patient because of misconduct or failure to act in a way appropriate to our practice. Such misconduct includes coming to an appointment when under the influence of alcohol or drugs, or using profanity in the office. Although only a small number of our patients violate these policies, we should nevertheless like all of our patients to be aware that these are our policies and that they should be adhered to.

We welcome you to our practice and hope that these policies will be acceptable to you.

Parent/Guardian name (if patient is minor)_____(mother/father/guardian)

Signature:_____Date:_____