Stevenson Dental Care

JACK D. CLIFTON, DDS

Up-to-date. Down-to-earth. Close to home.

52 NW Second Street
PO Box 709
Stevenson, WA 98648

509.427.8605

Patient Information

Patient's Name	Preferred Name	Date of Birth	Social Security #
Mailing address	City, State, Zip		Home Phone#
Physical address	City, State, Zip		Message Phone #
E-mail Address			Temporary Phone #
Patient's employer		How long employed	Business Phone #
Occupation (student?)	Banking Institution	Drivers License #	
Spouse's name	Spouses Date of Birth	Spouse's Social Security #	
Spouse's Employer	Employer's Address, City, State, Zip		Spouse's Business Phone #
Person to contact in case of emergency (not residing with you)	Address, City, State, Zip		Emergency Contact Phone #

If Patient is a Minor or Student

Mother's name	Mother's Date of Birth		Home Phone #
Street address	City, State, Zip	Mother's Social Security #	
Mother's employer	Occupation	How long employed	Business Phone #
Father's name	Father's Date of Birth		Home Phone #
Street address	City, State, Zip	Father's Social Security #	
Father's employer	Occupation	How long employed	Business Phone #

Insurance Information

Name of Plan	Policy #		Group # / Local #
Insurance Company address	City, State, Zip		Insurance Company Phone #
Name of Subscriber	Social Security #	Birth Date	Employer
Second Insurance Plan Name	Policy #		Group # / Local #
Second Insurance Company address	City, State, Zip		Insurance Company Phone #
Second Subscriber Name	Social Security #	Birth Date	Employer

STEVENSON DENTAL CARE FINANCIAL POLICY

PAYMENT OPTIONS:

We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. Full payment for your dental healthcare investment is required at the time of service, and may be paid by the following options:

1. **Cash or Check:** We will offer a 5% courtesy reduction of fees when you use this method, since this reduces our bookkeeping expenses. (Not available to insurance billed accounts or accounts paid by credit card).
2. **Credit Card:** Payment may be made by Visa, Mastercard, Discover or Debit Card.
3. **Insurance:** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, we will gladly process your insurance claim for you, estimate your deductible and the portion not covered by your insurance. Please keep in mind, however, that our estimates are based on information that you and your insurance company provide us and are subject to final approval by your insurance company. Therefore, the amount due our office is subject to change. The estimated amount not covered by your insurance is due at the time of service. If your insurance company pays directly to you, then you will be required to pay the full amount of your bill at the time of service. You are ultimately responsible for your account balance to Stevenson Dental Care. If payment is not recieved within 60 days from your insurance company, Stevenson Dental Care will require payment from you.
4. **Financing:** For those who need to spread the cost of treatment over time, a line of credit may be established. This requires filling out an application and obtaining pre-approval.

OUTSTANDING BALANCES:

Account balances that are 60 days old are considered delinquent. A monthly finance charge of $3.00 or 1.5% (18% APR), whichever is greater, will be added to cover the cost of additional handling.

MISSED APPOINTMENTS:

We do not over book our time beccause we want to give you the excellent individual treatment you deserve from our team. Your appointment time is reserved **exclusively** for you. Appointments are only scheduled at a patient's request, therefore, missed appointments with less than 24 hours notice will incur a charge of $25.00 or up to the cost of the scheduled procedure. *Please note: We cannot guarantee that we will be able to confirm your appointment ahead of time, so please take care to remember your appointment.*

NSF CHECKS:

All checks returned due to non-sufficient funds will incur a minimum service charge of $25.00.

ACKNOWLEDGEMENT:

I, the undersigned, agree to the payment policies of Stevenson Dental Care, and authorize any insurance payments to be paid directly to Stevenson Dental Care and/or Jack D. Clifton, DDS. I also authorize supporting claim documentation to be sent to my insurance company. I agree to pay all costs of collection, including but not limited to, costs when assigned to an outside collection agency, reasonable attorney's fees and expenses incurred in the event that Stevenson Dental Care must take action to collect on my account. I agree that the venue for any collection actions shall be in Skamania County, Washington. I certify all of the information I have provided to Stevenson Dental Care to be true and accurate to the best of my knowledge.

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Signature (Patient or Parent/Guardian if minor) Date