VIVIAN H. BAE D.D.S.
20710 1ST AVE SOUTH
DES MOINES, WA 98198

APPOINTMENT COMMITMENT AGREEMENT AND FINANCIAL POLICY

Your appointment is reserved exclusively for you. We ask that if you must cancel or reschedule your appointment, you do so only if truly necessary and give us a notice of at least 48 hours. If a notice less than 24 hours is given, or if you fail to show up for a confirmed appointment, we reserve the right to charge a failed appointment fee of $50. If you are running late to your appointment, please call us to assure we can still accommodate you and perform the treatment scheduled in the time remaining.

You may be responsible for paying a co-pay for today's visit. Or if not covered by insurance, payment is expected in full at each visit (unless an auto-charge payment plan is arranged prior to treatment).

Please indicate the payment option you will be using today:

Credit Card

Debit Card

Personal Check

Care Credit

Your co-pay is an **ESTIMATE ONLY**. Any balance or credit remaining after treatment will be billed or reimbursed accordingly. We are happy to help you utilize your insurance benefits by submitting claims on your behalf. However, it is unreasonable to expect our office to be aware of every detail of your insurance plan & we cannot be held responsible for claims denied due to plan limitations of **ANY** kind, including frequencies, benefit year changes, yearly maximums or waiting periods.

PLEASE BE AWARE that accounts not paid in full within 90 days from date of service, or 30 days from final insurance payment will be considered delinquent and forwarded to collections.

INFORMED CONSENT DISCLOSURE; ASSIGNMENT; RELEASE OF INFORMATION

I hereby authorize my insurance benefits to be paid directly to Dr. Vivian H. Bae, DDS. Furthermore, I understand and agree that I am ultimately and fully financially responsible for all services rendered to me by said office regardless of insurance coverage. In addition, I authorize the office of Dr. Vivian H. Bae, DDS to release any medical, dental or other records and information in accordance with the Health Insurance Portability and Accountability Act, which this office deems necessary in the conducting and disposition of my case.

I have read the above policies and acknowledge my responsibilities as a patient of this practice.

Signature of patient or person responsible for account Date

We are committed to helping you achieve optimal dental health and we look forward to serving you for many years to come!