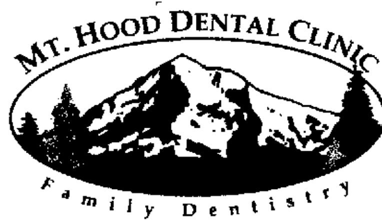

Jeremy S. Kato, D.D.S.

Financial Agreement and Insurance Disclaimer

All payments are required at time of service unless other arrangements are made in advance.

As a courtesy to you, we will bill your insurance. However, any estimate of charges and insurance payments are subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. It is understood that the patient/responsible party agrees to be fully responsible for payment of services regardless if benefits are denied in whole or part due to eligibility or plan limitations.

A 5% finance charge will be added monthly to any account over 90 days without prior arrangement unless held up by an insurance issue. In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed.
Any return check will be subject to a $35 bank charge as well as late fees, if applicable.

I have reviewed the above statement, and understand that I am responsible for all costs of dental treatment regardless of insurance coverage. I authorize the release of any information regarding insurance claims, and hereby authorize payment directly to Mt. Hood Dental Clinic of insurance benefits otherwise payable to me.

X____________________________________
Signed (Patient, or responsible party)

Date ____________________

39880 Pleasant Street • P.O. Box 458 • Sandy, Oregon 97055 • (503) 668-6226