SCHOOL OF DENTISTRY
UNIVERSITY of WASHINGTON

Financial Agreement

Thank you for choosing University of Washington School of Dentistry (UW SOD) for your dental care. We are committed to providing you quality and affordable dental care. The following information will help you understand how we work together and provide the information you need to meet your financial responsibilities for services you receive.

Dental and Medical coverage

Insurance coverage is a contract between you and your insurance company. You are responsible for knowing which services your insurance will cover before you receive care. If you're not sure about your insurance coverage, please ask your insurance company.

Insurance billing

- **Contracted coverage:** The School of Dentistry contracts with several insurance companies. If we are in your plan's network, our billing office will submit claims to your insurance company for the services you receive from us. You are responsible to pay co-pays or any portion not covered by your insurance at time of service.
- **Non-contracted:** If the School of Dentistry does not contract with your insurance plan, we will bill your insurance as a courtesy. You are responsible for payment at the time of service and your insurance company will reimburse you directly.

Services not covered by your insurance plan

Not all services are covered by your insurance plan. If you receive treatment that is not covered, you will be responsible for the full cost at the time of service.

Adult bringing a minor (under 18 years of age) for treatment

A parent or guardian who brings a minor to his or her appointment is responsible for any payments due at the time of service. If a responsible adult is not present, treatment that is not urgent may be rescheduled.

Missed appointments

If you miss an appointment, or do not cancel your appointment within 24 hours, we may charge you a cancellation fee. This fee is your responsibility and will be billed directly to you. Please note that chronic lateness to appointments or more than two cancelled or failed appointments may be cause for discontinuing your care at the School of Dentistry.

Billing

Payment for all bills is due within 30 days from date of service. You may pay by check, debit or credit card (Visa, MasterCard or Discover). If we do not receive payment, we will continue to send you bills until we receive payment in full. Unpaid balances may be referred to a collection agency.

By signing below, I agree:

1. That UW SOD may share any financial information I provide to facilitate payment.
2. To assign UW SOD all insurance benefits payable for services rendered.
3. To pay in full at time of service if I do not have insurance coverage for my care.
4. To pay UW SOD for balances remaining after insurance benefits are paid, unless prohibited by law or contract.
5. To pay any coinsurance or deductibles required by the terms of my insurance benefits.
6. To pay for any services not covered by my dental or medical insurance company.
7. To notify UW SOD of changes to my insurance coverage and/or address.
8. That UW SOD may impose reasonable interest, late charges, costs and/or reasonable attorney's fees should my account become delinquent.
9. That any lawsuit for collection of my account may be brought in King County, Washington.

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I understand that:

1. If UW SOD does not contract with my insurance plan, the UW SOD will process my insurance claim as a courtesy and I am responsible for payment at the time of service.
2. I am responsible for knowing my insurance coverage and benefits. I may request a pre-authorization or predetermination for services from my insurance.
3. If I present a current Washington State Medicaid Provider One Card, benefit eligibility will be verified from the Provider One website at registration. Certain procedures require preauthorization before the onset of care, and in this case, treatment may be delayed until the authorization is received.
4. Medicare covers limited dental procedures and only when related to a medical condition, unless a supplemental dental insurance has been purchased. I am responsible for providing this dental insurance information at the time of registration or service.
5. The UW SOD and other UW entities each bill seperately for services.
6. Certain procedures, such as crowns, inlays, onlays, dentures and bridgework, require an advance deposit. My care provider will inform me of these procedures when discussing my plan of care.
7. If I receive a service that is not covered by my insurance plan or if an insurance claim is unpaid after 8 weeks, I will be responsible for the full cost.
8. Checks returned unpaid by my bank for insufficient funds are subject to a $25 service fee.

Statement to permit payment of Medicare/Medicaid or insurance benefits to provider

I request payment of authorized Medicare/Medicaid benefits for any services furnished to me by UW SOD to be made payable directly to UW SOD. I authorize any holder of medical and other information about me to release to Medicare/Medicaid and its agents or other insurance providers any information needed to determine these benefits or benefits for related services.

<u>Signature</u>

By signing below, I agree to the terms of UW School of Dentistry's Financial Agreement.

SIGNATURE (PATIENT OR AUTHORIZED REPRESENTATIVE)	PRINT NAME	DATE

IF SIGNED BY PERSON OTHER THAN PATIENT, CHECK RELATION TO PATIENT:

- ☐ 1. Guardian
- ☐ 2. Durable Healthcare Power of Attorney
- ☐ 3. Spouse/Registered Domestic Partner
- ☐ 4. Adult Child(ren)
- ☐ 5. Parent(s)
- ☐ 6. Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:

- ☐ 1. Guardian/Legal Custodian
- ☐ 2. Court-authorized person for child in out-of-home placement
- ☐ 3. Parent(s)
- ☐ 4. Holder of signed authorization from parent(s)
- ☐ 5. Adult representing self to be a relative responsible for the minor's health

FOR OFFICE USE ONLY:

(<u>This section below is to be filled out by UW School of Dentistry staff only</u>)

We are unable to obtain acknowledgement from this individual at this time, but immediate treatment is needed for the following reason(s):