

TANASBOURNE FAMILY DENTAL

Daniel B Lee, DDS
17895 NW Evergreen Pkwy #150
Beaverton, OR 97006
(503)533-9868

I understand that I am fully responsible for all fees related to my dental care and agree to pay in full any balance not paid by my insurance company within 60 days of service.

I understand that my estimated patient portion is due at time of service.

I understand that I will be charged a \$60.00 failed appointment fee or an appointment cancelled or changed without 24 hour notice.

I agree to pay a service fee of 18% per annum on any balance due over 60 days on my account after insurance pays if a balance remains.

I understand that I will be given an estimate for dental treatment. This is an estimate only. I understand that this may change due to unforeseen circumstances such as my dental health, insurance fee schedules and limitations, or services not covered by my insurance plan.

I understand that my insurance is billed as a courtesy. My insurance is a contract between my insurance company, my employer, and myself; not with Dr. Daniel Lee.

I agree to pay all collection costs involved should my account be submitted to a collection service.

Patient (Parent or Guardian) Signature

Date

Please Print Name