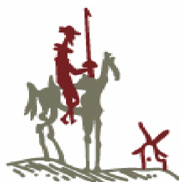

Mid-Valley Dental Associates

Geoffrey A. Berg, DMD
Tyler L. Bryan, DMD
Steven M. Deming, DDS
Brian D. Tidwell, DDS

Albany Location	**Eugene Location**	**Philomath Location**	**Salem Location**	**Dallas Location**
2825 Wiletta ST SW Suite A	1241 Oak Street	2811 Main Street	3545 Lancaster Dr.	197 SE Washington
Albany, OR 97321	Eugene, OR 97401	Philomath, OR 97370	Salem, OR 97305	Dallas, OR 97338
(541) 928-2301	(541) 686-9897	(541) 929-5227	(503) 371-9897	(503) 623-2389

FINANCIAL AGREEMENT & POLICIES

This statement is to inform you of our financial policy. We are committed to providing you with the finest quality care using only the best material and technology available in the market today. All charges you incur are your responsibility regardless of your insurance coverage.

Insurance coverage is a valuable asset in restoring and maintaining good oral health. By providing us with accurate insurance information, you enable us to process your claims in a timely manner. We may also be able to determine benefits prior to treatment, which provides you with important deductible and co-payment information. Our relationship is with you as our patient, not the insurance company. Our office is not a party to that contract and final responsibility of payment is yours. As a courtesy to you, we will help you process your insurance claims. If there is no payment from the insurance company within sixty (60) days, you will be expected to pay the balance in full.

Your portion of the payment is due at the time that services are rendered. We accept cash, money orders, personal checks, Visa, MasterCard, and Discover. We also offer no interest and low interest extended payment plans through Citi Health Card and Care Credit.

Returned checks for any reason, will be assessed a processing fee of $25.00. Balances older than 60 days are subject to collection fees and finance charges at the rate of 12% annually. NOTE: If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and collection costs.

All missed appointments (those without 24 hours notice) will be assessed a charge of $50.00.

I have read the above statement of the Financial Agreement and Policies, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account.

Signature____**Date**____________________