David W. Compton, DMD, MS, PC
(503) 652-2615

Financial Policy

All fees/estimated co-payments are due at time of service.

We accept the following forms of payment:

Cash - Personal Check - Visa - MasterCard - Discover - American Express

Financing available through Care Credit

All accounts with balances over 90 days will be charged a $3.00 monthly statement fee.

Our Policy on Insurance & Fees

Please remember that insurance estimates are based on information provided by you and your insurance company and may not reflect what your insurance carrier will actually pay. Insurance companies do not guarantee any insurance estimate whether written or verbal. We will assist you in collecting your insurance benefits; however, you must realize that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. If you are disputing coverage, we ask that you contact your insurance company prior to calling us. Not every service is a covered benefit with all insurance contracts. Many insurance plans are selective in what services they cover. Services cannot be provided on the assumption that the charges will be paid by the insurance company; therefore, **the patient is responsible for the charges regardless of insurance coverage.**

2. All returned NSF checks will be subject to a $25.00 processing fee.

3. We reserve the right to charge a $60.00 fee (unless otherwise specified) for missed appointments or cancellations without 48 hour notice.

4. If your account is turned over to our collection agency, you will be charged a collection fee of $75.00.

Assignment of Insurance Benefits

I hereby assign David W. Compton, DMD, MS, PC, the insurance benefits which are otherwise payable to me for his charges and direct the insurance payments to be made directly to this office. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original.

I understand that **I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize assignee to release all information necessary to secure payment.

I have read and agree to the above terms.

Signature of Responsible Party:_____ Date:_____