Our Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment; and is a very important part of your exchange with our Practice for services rendered. The following is a statement of our financial policy, which we would like you to read, and sign prior to any treatment.

FULL PAYMENT OF FEES & COPAYMENTS ARE REQUESTED AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, CARE CREDIT, AND OTHER EXTENDED PAYMENT PLANS WITH PRIOR CREDIT APPROVAL.

Please indicate that you have read each policy by placing your initials at the end of each section below:

Dental Insurance

Please remember that your dental insurance is your responsibility and only a supplement to cover dental expenses but we can help. **Regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you, the patient, are responsible for the total treatment fee.** As a courtesy to you, we can accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. Our estimates are based on limited information obtained from your insurance company. We allow 60 days for your insurance company to make a payment. After this time all inquiries (follow-up) and payments due become your responsibility. It is necessary that you accept responsibility for full payment of service fees not paid by insurance regardless of the reason for non-payment. X_____

Adult Patients

Notification of changes in insurance, medical history, martial status, residence and telephone numbers are your responsibility for yourself and minor children prior to your appointment. X_____

Minor Patients

It is state law for a parent/guardian of a minor child under the age of 16 to remain in the office while the child is being treated. The parent/guardian **accompanying** a minor is responsible for payment of all charges. For patients 16 years or older who come unaccompanied by a parent/guardian; treatment may be performed following pre-payment for services by the responsible parent or guardian. X_____

Missed Appointments

Since providing quality treatment for all our patients in a timely manner is a major focus in our practice philosophy, we would like to clarify our appointment guidelines with you and ask that you assist us in this endeavor. There will be absolutely no charge for your need to reschedule an appointment provided you give us 48 hour notice and you contact us during business hours. This would allow us to give this time to another patient who is in need and waiting for an appointment. Not showing for 2 appointments will result in a $50.00 reservation fee being required to reserve time in our schedule for future appointments. 3 or more missed appointments will result in the need for pre-payment for your visit. Last minute cancellations can cause hardships for many individuals. It is our sincere hope that you will accept these guidelines and join us in our efforts to provide quality time for you and each valued patient in our practice. X_____

Dental Records & X-rays:

Pursuant to California Law, our office is required to keep dental records for 7 years. For a printed copy of full dental records, there will be a charge of $35.00. For a printed copy of the radiographs (x-rays) only, the charge will be $20.00. We will send a printed copy of dental records / X-rays once payment is received. We can do our best to scan and print out the copy of x-rays, but the quality of a copy would be subjective to the x-ray reader and may not be 100% duplicated as the original. X_____

Finance Charges and Outside Collections

A monthly finance charge of 1.5% will be charged to all accounts past 60 days. If any unpaid balance becomes 90 days past due, there will be a 30% collection fee added to your account balance. If in default, you are responsible to pay for services rendered, including reasonable attorney's fees and costs of collections. Non-sufficient fund checks will be accessed a $45.00 service charge. In addition, refund requests on pre-paid services or credit balances are subject to a 30-day processing period and a 5% administrative handling fee up to a maximum fee of $300.00. X_____

Please let us know if you have any questions or concerns.

I have read, understand, and agree to this Financial Policy.

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Signature of Patient or Responsible Party **Print Name** **Date**