Patient Appointments and Financial Policy

Welcome to Dr. Lee's dental office and thank you for choosing us to be your dental health care provider. We are committed to provide you with quality care and therefore excellent oral health. To optimize communication with you about scheduling for your treatment and paying for it, we have prepared this sheet to go over questions that we have dealt with over the years. Please read this carefully and ask any question before you sign and approve the treatment.

Payment

1. Payment is due at the time that service is provided. Cash, personal checks, and all major U.S. credit cards are accepted. Estimated copayment, deductible, and co-insurance for patients with dental insurance will be collected at the time of service as well.

2. Third-party financing such as CareCredit is available upon request and approval.

3. No in-house payment plan is available but we can set up arrangement and you can make monthly pre-payment before the treatment.

4. We do our best to let you know the expected expenses before the appointment. If you do not have this information or have any question about it, please do not hesistate to ask.

Insurance

1. We process all your dental insurance claims as a courtesy. Please undersatand we are your dental care provider and not your dental insurnace company. Benefits and coverage can very significantly depending on your contract. One dental insurnace company may sell multiple products with completely different terms.

2. "Pre-authorization" or "Pre-treatment": This is a document from your insurnace company in response to our request. The only purpose of it is to inform both our office and you of the estimated insurance benefits for the proceedure. **This does not guarentee payment**. Multiple factors such as remaining annual benefits can easily change the final payment from your dental insurance company. **Therefore, we ask you kindly to call your dental insurance company if you have any questions regarding their pre-treatment estiamte**. We can help you review and understand your documents but we have no control over how the insurnace company determines your benefits. *Initial* _____

3. Our practice is committed to provide great quality treatment to our patients. We charge what is the usual and customary fees for our area. The patient is ultimately responsible for the difference between the office fee and the insurance payment. *Initial* _____

4. By reviewing and signing this form, we ask you to authorize youtr dental insurance company to send payment for the treatment directly to our office. This will avoid the trouble of paying everything for the treatment up front. You will also be authroizing us to release any health-related information of your or your child, and treatment plan to your insruance company in order to etermind benefits.

5. Please make sure to provide us with your up-to-date dental insurance information before your visit. If payment is not recived from your insurance company, or the claim is denied, you, the patient, are

responsible for the balance. *Initial* _____

6. We are happy to assist you to facilitate the claim process and use your coverage, however we cannot dispute with your insurance over the claim. You will be the one who needs to contact them and appeal their decision if need be. *Initial* _____

Minors
A minor must be accompanied by a Parent or Legal Guardian, who is responsible for consenting for the treatment and making full payment at the time of service.

Missed Appointments and Cancellations
We strive to provide quality treatement in a timely manner. We appreciate at least a 24-hour notice for any cancellations or rescheduling. We undertand that emergencies do happen in life, so if you need to move your appointment, be sure to contact us and we can see what we can do for you. If there is a history of multiple missed or last-minute cancellations, we will require a security deposite of $50.00 for future appointments. Patients who miss multiple appointments without reasonable causes will be dismissed from our office.

By reviewing this consent form and signing below, you are agreeing to having your dental insurnace company to send payments directly to our office, providing us with your up-to-date insurnace, being ultimately responsible for any charges that your dental insurnace does not cover, and letting us know of any changes in your schedule ahead of time. We truly appriciate your understanding and cooperation.

_____	_____	_____
Print patient name	Patient or guardian signature	Date