FINANCIAL POLICIES AND MISSED APPOINTMENT POLICIES

In order to enhance communication and promote understanding regarding this office's financial and missed appointment policy, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please speak to the office manager. Thank you.

Privacy Policy: This office follows and maintains HIPPA privacy standards and does not share records without your permission. A copy is always available for you online or in the office.

Have you been provided a copy of the HIPPA policy? □ Yes □ No

PATIENT PAYMENT: Pacific Dental Excellence has a general policy that payment is due and payable at the time of treatment. Professional services are charged directly to the patient and the patient is solely and personally responsible for payment.
For your convenience we accept cash, check, all major credit cards, and have outside financing available.
Please Note: the cost of dental treatment, even with insurance, can be in the hundreds or even thousands of dollars. Our office has made arrangements with CareCredit and Springstone Financing to help you get the treatment you need now.

Are you interested in applying for financing? □ Yes □ No

Balances over 60 days will incur an interest charge of 1.5% per month and after 90 days, an additional $5.00 rebilling fee per statement will be charged. Returned checks will have an additional fee of $25.00 added to the amount of the returned check. Please contact the office manager for more information on any of the above payment options.

INSURANCE: We are happy to bill both your primary and secondary insurance carriers as a courtesy for our patients. Please understand that each patient is ultimately responsible for the cost of services rendered. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company.

1. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts.
2. If the insurance company does not pay your balance in full within 30 days, we will ask that you contact the carrier to help speed things up.
3. If the insurance company does not pay in full within 60 days, we will require you to pay the balance due with cash, personal check, MasterCar4d, Discover, American Express or Visa.
4. We will do our best to estimate insurance coverage and patient portions due (we will send pre-estimates for services over $500 at your request. If the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment is expected within 10 days after the statement date.

Will you be using Dental Insurance? □ Yes □ No

Please Sign Back Side

NO SHOW/MISSED APPOINTMENTMENTS: We request notice of 48 hours for cancellation of appointments. If appropriate notice is not given, a charge of $50 may be assessed to the patient's account and patient forfeits any deposits or discounts that have been applied.
For appointments longer than 1 hour, the charge will increase, i.e., $75.00 for a two hour appointment, $100.00 for a 3 hour appointment or on any Saturday appointment. We understand that sometimes last minute cancellations are unavoidable. Individual circumstances may be discussed with the office manager and/or the dentist.

REFUNDS: All refund requests must be submitted in writing to the office for consideration. Any available refunds will be issued within two weeks of the office receiving the request in the form of the original payment. Cash refunds will be issued by check only.
***Please understand this office will not consider any refunds for completed treatment. I**f a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or the dentist. In the event of a refund the patient will be responsible for any of the fees incurred by the office for treatment and or financing.

CREDITS ON AN ACCOUNT: If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave a credit on the account to be applied towards future treatment.

Patient Name: _____

Patient Signature: _____ Date: _____

Guarantor Name: _____ Guarantor Signature: _____