William B. Chan & Associates

FINANCIAL POLICY

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by William B. Chan & Associates and/or the dental team for myself or my dependent(s). These include deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that there will be a $35 charge to all accounts for which a check payment is returned.

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time. **A $50 cancellation fee may apply if I do not provide notice of cancellation at least 48 hours prior to my scheduled appointment time.**

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for treatment less than two hundred dollars ($200), payment in full is due at the time of service. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Signature:____ Date:_________________

Minor/Child Consent

I, being the parent or legal guardian of ________________________________, do hereby request and authorize the dental staff to perform necessary services for my child, including, but not limited to radiographs (x-rays) and the administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so that I may seek reimbursement.

Signature:____ Date:__________________

(over)

Insurance estimates are provided as a courtesy to our patients. In the event that your insurance carrier pays less than the estimated amount, you are responsible for the balance.

As treatment progresses, modifications may be necessary which could affect the fee. Should any modifications occur, the change in fee will be discussed at the earliest possible time before starting any additional treatment. Any fees discussed at the time of treatment planning are valid for 90 days only.

Once a treatment plan has been agreed upon and signed, any lab work is immediately started for your benefit. If procedures are cancelled, the patient is responsible for the lab fee.

Please note that some insurance companies will substitute benefits for a silver filling instead of paying full benefits for a white (resin) filling. Please contact your insurance company if you have any questions about this.

I acknowledge that I have been informed of the above fees and proposed treatment. I understand that by not completing treatment, my oral condition may deteriorate and need reassessment in the future.

Signature:____ Date:____________________