

KEVIN CHANG DDS, INC.

FAMILY AND COSMETIC DENTISTRY

Financial Policy

Thank you for choosing Kevin Chang DDS, Inc. as your dental provider. We pledge to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable as possible for our patients. PLEASE read this carefully and ask any questions or any concerns you may have BEFORE treatment is rendered. **SUBMISSION TO TREATMENT IMPLIES CONSENT TO TERMS OF AGREEMENT.**

INSURANCE: For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. If this office is able to accept your insurance company's assignment, the patient is **FULLY RESPONSIBLE** for the charges of treatment rendered. Your insurance may not cover the services or may only partially cover them. ***ANY ESTIMATE GIVEN BY THIS OFFICE IS CONSIDERED A GUIDELINE UNTIL THE FINAL INSURANCE PAYMENT IS RECEIVED AND THE PATIENT'S ACCOUNT IS RECONCILED. THE OFFICE CAN MAKE NO GUARANTEE OF THE ACTUAL PAYMENT BY THE INSURANCE COMPANY.***

MISSED APPOINTMENTS: When we schedule your appointment, the time is **reserved exclusively for you**. We ask that you please contact us within a 24-hour period prior to your appointment if you are unable to keep the previously scheduled appointment. Please keep in mind there are other patients who need that time for necessary treatment. A fee of **\$50** will be charged to patients who miss or cancel more than one appointment in a calendar year without at least a 24-hour notice.

PAYMENT OPTIONS: Kevin Chang DDS Inc. requires payment **at time of service**. For treatment plans requiring multiple appointments, alternative payment arrangements may be provided. Kevin Chang DDS Inc. accepts the following payment methods: **Cash, Check, Visa, MasterCard, Discover, Debit or CareCredit**. Due to high Credit Card processing fees, we will apply a 3% credit card processing fee to payment amounts for Debit & Credit card payments.

RETURNED CHECKS: There is a \$15 fee for returned checks. The check must be picked up personally and cash must be paid to cover the check and the fee.

COLLECTION FEES: Fees incurred to enforce payment required by this agreement will be charged to patients whose failure to pay, required these fees to be incurred.

Accounts past due 60+ days will be subject to accrue 18% interest rate annually spread out over 12 months

If you have any questions please do not hesitate to ask. We are here to help you get the dentistry you want, need and deserve.

Patient, Parent, or Guardian Signature

Date

Patient name (Please Print)

Date