San Jose Sedation & Implant Dentistry
Dr Henry Chang

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FINANCIAL POLICY

We are committed to providing you the best possible care. If you have dental insurance, we will be happy to help you receive maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Estimate patient payments are due when services are rendered. We will be happy to bill your insurance claim as a courtesy to you. However, any insurance claims not paid within 60 days from the date filed will become your responsibility. All accounts 30 days or older will be assessed a finance charge of 21% annually or 1.75% monthly. You will receive a statement regarding your account on a monthly basis. In order to ensure proper claim submission you must notify us of your current insurance on or before the day of treatment. **You will be responsible for a $35.00 return fee for any check returned for insufficient funds.** In addition, any non-insurance account that is 90 days past due, will be automatically transferred to our collection agency. We will gladly discuss your proposed treatment and answer any questions relating to your insurance or account. You must realize however,

***Your insurance is a contract between you and your insurance company. We are not a party to that contract!**

***Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they do not cover.**

We must emphasize that as health care providers, our relationship is with you **NOT YOUR INSURANCE COMPANY.** While the filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately your responsibility. We do not have a relationship with any FSA or HSA accounts. As a courtesy we can provide a copy of your ledger of your account to turn into your FSA or HSA account. Communication can often avoid problems. We encourage you to contact us if you have any questions or any uncertainties, please do not hesitate to ask anyone on our team. We are here to help you!

I have read an understand the above financial policy.

_____ _____
Print patient name Date

_____ _____
Signature of patient/parent or guardian Date

Revised 8/2016