LAM, WELKIE,
& ASSOCIATES
FAMILY AND COSMETIC DENTISTRY

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OFFICE FINANCIAL & APPOINTMENT POLICY

PATIENT NAME: DATE:

THANK YOU FOR CHOOSING US AS YOUR DENTAL HEALTHCARE PROVIDER. WE ARE COMMITTED TO PROVIDING YOU WITH THE HIGHEST QUALITY DENTAL CARE SO THAT YOU MAY ATTAIN AND MAINTAIN EXCELLENT ORAL HEALTH. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY, WHICH WE REQUIRE THAT YOU READ, AGREE TO AND SIGN PRIOR TO ANY FUTURE TREATMENT.

PLEASE NOTE: OUR OFFICE ACCEPTS CASH, PERSONAL CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS. ADDITIONAL FEES WILL BE APPLIED FOR RETURNED CHECKS AND ALL BALANCES OVER 90 DAYS ARE SUBJECT TO A $35.00 LATE FEE.

FOR OUR PATIENTS WITH DENTAL BENEFITS ("DENTAL INSURANCE")

• AS A COURTESY TO YOU, WE WILL HELP YOU PROCESS ALL OF YOUR DENTAL INSURANCE CLAIMS. PLEASE UNDERSTAND THAT WE WILL PROVIDE AN INSURANCE ESTIMATE TO YOU; HOWEVER, IT IS NOT A GUARANTEE THAT YOUR INSURANCE WILL PAY EXACTLY AS ESTIMATED. YOUR INSURANCE COMPANY AND YOUR PLAN BENEFITS ULTIMATELY DETERMINE THE AMOUNT PAID. INSURANCE COVERAGE IS SUBJECT TO LIMITATIONS, EXCLUSIONS, WAITING PERIODS, FREQUENCY, AGE RESTRICTIONS, DEDUCTIBLES AND MAXIMUMS WHICH ARE YOUR RESPONSIBILITY. PLEASE CONTACT YOUR INSURANCE COMPANY FOR DETAILS OF YOUR BENEFITS. WE WILL DO ALL WE CAN TO ENSURE YOUR ESTIMATE IS AS ACCURATE AS POSSIBLE. YOUR ESTIMATED INSURANCE BENEFIT MAY DIFFER DUE TO A NUMBER OF REASONS SPECIFICALLY RELATED TO YOUR PLAN.

• ALL CHARGES YOU INCUR ARE ULTIMATELY YOUR RESPONSIBILITY, REGARDLESS OF YOUR INSURANCE COVERAGE. WE MUST EMPHASIZE THAT AS YOUR DENTAL CARE PROVIDER, OUR RELATIONSHIP IS WITH YOU, OUR PATIENT, NOT WITH YOUR INSURANCE COMPANY. WE ARE INVESTED IN YOUR HEALTH. YOUR INSURANCE PLAN IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.

• OUR PRACTICE IS COMMITTED TO PROVIDING THE BEST TREATMENT FOR OUR PATIENTS. WE CHARGE WHAT IS USUAL AND CUSTOMARY FOR OUR AREA. WHEN YOUR INSURANCE DENIES COVERAGE OR PROVIDES AN ALTERNATE BENEFIT FOR A PROCEDURE, YOU ARE RESPONSIBLE FOR PAYMENT REGARDLESS OF ANY INSURANCE COMPANY'S ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES.

• INSURANCE PAYMENTS ARE ORDINARILY RECEIVED WITHIN 30-60 DAYS FROM THE TIME OF FILING A CLAIM. IF YOUR INSURANCE COMPANY HAS NOT MADE PAYMENT WITHIN 60 DAYS, WE WILL RESUBMIT YOUR CLAIM ONE ADDITIONAL TIME AS A COURTESY TO YOU. WE ALSO ASK THAT YOU CONTACT YOUR INSURANCE COMPANY TO MAKE SURE PAYMENT IS EXPECTED. IF PAYMENT IS NOT RECEIVED, YOUR CLAIM IS DENIED, OR WE DO NOT RECEIVE PAYMENT WITHIN 90 DAYS OF SERVICE, YOU WILL BE RESPONSIBLE FOR PAYING THE FULL AMOUNT AT THAT TIME. IF WE EVENTUALLY RECEIVE PAYMENT FROM YOUR INSURANCE COMPANY FOR SERVICES RENDERED IN EXCESS OF THE AMOUNT DUE, IT WILL BE REFUNDED TO YOU AS A CHECK WITHIN 7 DAYS.

• WE WILL COOPERATE FULLY WITH THE REGULATIONS AND REQUESTS OF YOUR INSURANCE COMPANY THAT MAY ASSIST IN THE CLAIM BEING PAID. OUR OFFICE WILL NOT, HOWEVER, ENTER INTO A DISPUTE WITH YOUR INSURANCE COMPANY OVER ANY CLAIM.

MISSED APPOINTMENTS AND CANCELLATIONS

YOUR TIME IS IMPORTANT TO US – WE ASK YOU TO TREAT OUR TIME THE SAME WAY. OUR PATIENTS ARE CONSISTENTLY SEEN IN A TIMELY MANNER, AND WE STRIVE TO PROVIDE TREATMENT IN AS FEW VISITS AS NECESSARY. IN ORDER TO PROVIDE THE BEST SERVICES TO OUR PATIENTS, WE REQUIRE 48 HOUR NOTICE FOR CANCELLATIONS OR FOR RE-SCHEDULING YOUR APPOINTMENTS. FOR MONDAY APPOINTMENTS, THIS MEANS THURSDAY BY END OF DAY. A BROKEN APPOINTMENT IS A LOSS TO THREE PEOPLE - THE PATIENT WHO MISSED THE VALUABLE TIME, THE PATIENT WHO COULD HAVE TAKEN THE VALUABLE TIME, AND THE DOCTOR WHO WAS FULLY STAFFED AND PREPARED FOR THE APPOINTMENT.

WE UNDERSTAND THAT UNFORESEEN CIRCUMSTANCES ARISE WHICH MIGHT RESULT IN CANCELING OR MISSING YOUR APPOINTMENT. FOR CLARITY AND CONSISTENCY, WE HAVE DEVELOPED THE FOLLOWING POLICY FOR CANCELLATIONS LESS THAN 48 HOURS PRIOR TO YOUR APPOINTMENT:

MISSED APPOINTMENT	1	2*	3	4
FEE (HYGIENE/DOCTOR)	COURTESY	$35/50	$50/75	DISMISSAL

* IF YOU ARRIVE ON TIME FOR YOUR NEXT 3 APPOINTMENTS THE LATE FEE WILL BE CREDITED BACK TO YOUR ACCOUNT

PLEASE NOTE: PATIENTS WHO ARE 15 MINUTES OR MORE LATE FOR THEIR APPOINTMENT MAY NEED TO BE RESCHEDULED – THIS IS CONSIDERED A MISSED APPOINTMENT. MISSED APPOINTMENT FEES ARE DUE AT YOUR NEXT VISIT AND PRIOR TO ANY ADDITIONAL TREATMENT.

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I UNDERSTAND THAT ULTIMATE RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED IN THIS OFFICE FOR MYSELF OR MY DEPENDENTS IS MINE.

SIGNATURE: DATE: