Chino Spectrum Dental
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OFFICE FINANCIAL POLICY

Thank you for choosing us as your dental care provider! We are committed to provide you quality dental care and exceptional service. Please understand that we request **FULL PAYMENT OF FEES AND COPAYMENTS AT TIME OF SERVICE** unless prior financial arrangements have been made. In order to maintain a vital business operation, our practice depends upon reimbursement from our patients for the costs incurred in their care. The following is our financial policy, which we would like you to read and sign prior to any treatment.

Methods of Payment

1. **Cash/Check**: Any non-sufficient fund, returned or cancelled check will be charged **$25** per check. A **5% bookkeeping courtesy** will be extended to treatment totaling $1,000 or more, if full payment is made by cash or check in advance of treatment (*not applicable with any other discount or promotion*).
2. **Debit/Credit Cards**: Visa or MasterCard. All credit/debit card payments will incur a **50 cent** handling fee.

Dental Insurance: Understanding the value of dental insurance, our office will assist you in obtaining the maximum benefits of your plan. As a courtesy to you, we will file insurance claims on your behalf, collect your estimated copayments and deductibles at time of service, and accept assignment of benefit payments from your insurance company. Our estimates are based on limited information obtained from you and your insurance company. Depending on eligibility, exclusions, limitations, and restrictions of each insurance plan, we cannot guarantee what your plan will pay. The patient/responsible party is financially responsible for all dental services provided to him/her and any dependents.

Information Update: Notification of changes in insurance, medical history, marital status, residence, phone numbers and email addresses are your responsibility for yourself and dependents prior to your appointment.

Minor Patients: Under state law, a parent/guardian of a patient under the age of 16 must remain in the office during treatment. For patients 16 years or older who come alone or accompanied by another adult relative, treatment may be performed if prior written consent and pre-payment for services have been made by parent/guardian.

Cancelled/Broken Appointments: Out of respect for all our patients, please give us **48 hour notice during business hours for cancellation**. **Broken or cancelled appointments without 48 hour advanced notice will be charged $25 per occurrence**. A history of excessive cancelled/broken appointments will require a $50 reservation fee or pre-payment for your visit to reserve your appointment in our schedule. Our office is a private family practice and we do not book multiple patients at one time to avoid keeping you waiting. Your appointment reserves time just for you and last minute cancellations can cause hardships for other patients and the office. It is our sincere hope that you will accept these guidelines and join us in our efforts to provide quality time for you and each valued patient in our practice.

Dental Records and X-rays: In case of relocation or transfer of dentist and pursuant to HIPAA law, any request for copy of dental records/x-rays must be in writing. There will be a charge of $35 for a printed copy of full dental records or $25 for a printed copy of X-rays only. We will send a printed copy of dental records/X-rays once payment is received and within 15 days of such written request. Despite our best effort to scan, copy or print the records/X-rays, the quality of a copy may not be 100% duplicated as the original.

Finance Charges/Collection Agency: Any balance not paid by insurance 60 days after the service date for any reason will become the patient's responsibility. A finance charge of 1.5% per month (18% APR) on the unpaid balance will be charged on all accounts exceeding 60 days unless prior written arrangements have been made. Accounts with unpaid balance beyond 60 days or after 3 billing statements will incur an additional 20-50% collection fee. If in default, you will be responsible for all legal fees and costs of collections. Credit balance refunds are subject to a 10-business day processing period after such request.

I have read, understand, and agree to this policy above.

_____	_____	_____
Patient's Name	Patient's/Guardian's Signature	Date