lee
FAMILY **DENTISTRY** P.C.

FINANCIAL POLICY

Please read entire policy

Thank you for choosing Dr. Lee as your dental health care provider. We are committed to providing you with the highest quality dental care so that you may fully attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to and sign prior to **any** treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, Visa, MasterCard, American Express and Discover. All returned checks will be subject to additional fees.

Personal payment plans are NOT an option.
If you require financial assistance please ask for information about the **Care Credit program**.

This office reserves the right to charge up to $50.00 for any appointment that is canceled with less than 24 hours notice or if you fail your appointment without any notice.

As a courtesy this office will process your insurance claims. We will provide an **estimate** to you, but it is not a guarantee that your insurance company will pay exactly as we **estimated**. Your insurance plan is a contract between you, your employer and your insurance company. Our office is not a party to that contract. This office has no control on how your insurance company pays your claims.

All charges incurred are your responsibility regardless of your insurance coverage and regardless of what your insurance company deems usual and customary rates.

Insurance claims are usually received within 30 days from the time of filing. If your claim has not been paid within 30 days, you will be billed for the balance due. It will then be your responsibility to collect on the unpaid balance and if insurance does pay, we will issue you a refund check.

We ask that you sign this form and any other documents that may be required by your insurance company. This form also instructs your insurance company to make payments directly to this office.

If it becomes necessary, you will be responsible for any collection/legal fees incurred while trying to collect a past due balance.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO LEE FAMILY DENTISTRY.

Signature of Patient or Guarantor, if Minor _____

Date _____