**Alice H. Tai, D.D.S.**
**Periodontics**
**525 Bollinger Canyon Way, Suite 103, San Ramon, CA 94582 (925) 735-1881 FAX (925) 735-1440**

Thank your for choosing us as your dental health provider. We are committed to your treatment being successful. Our aim is to provide each patient with the finest periodontal care in a professional environment that inspires trust and confidence. Our Periodontal office is a business that must be managed efficiently if we are to continue serving our community with quality periodontal care. Our fees are fair and reflect the care and expertise with which we treat each patient.

## INSURANCE

As a courtesy to you, we accept assignment of insurance benefits from most insurance companies. All insurance companies will be processed through our office on a company by company basis. At the time services are rendered, the deductible, estimated patient portion and any uncovered services will be due. Any patient portion remaining after insurance has paid, above and beyond what we estimated, is due and payable upon receipt of your initial statement. Your insurance policy is a contract between you and your insurance company. Patients who carry dental insurance should remember that all dental services performed are charged directly to the patient and not the insurance company. We do accept Visa, Master Card, or Discover Card by phone for your convenience. All patients with insurance are fortunate, as it will help offset their investment. We are happy to assist you in maximizing your insurance benefits without compromising our standard of care for you.

## INSURANCE ASSIGNMENT RELEASE

I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment within 90 days, I will be responsible for the full amount owed to Alice H. Tai, D.D.S. I understand that after the insurance company pays Alice H. Tai, D.D.S. there could still be a balance remaining, for which I am responsible. My signature on this form constitutes signature on file. This enables this dental office to submit my insurance forms for me without my signature. I hereby instruct and direct my insurance company, or if I have dual coverage, both of my insurance companies to pay by check made out and mailed to Alice H. Tai, D.D.S. If my current policy or policies prohibit direct payment to Alice H. Tai, D.D.S., I will pay in full at the time of treatment and hereby instruct and direct my insurance company to make the check out to me.

## PAYMENT OPTIONS and ACCOUNT INFORMATION

To keep our fees from rising considerably and to minimize the expenses of billing and bookkeeping, we offer our patients several payment options. **We ask that all accounts be paid at the time services are rendered.** If a statement becomes necessary, and the balance is over 30 days, a billing fee will be charged at the rate of 1.5% per month, or $5.00, whichever is greater. In the event we receive a returned check for insufficient funds or a closed account, there will be a $35.00 fee charged to your account. Collection fees of 35% of the account balance will be added to any balance turned over for collection purposes.
We accept: cash, personal check, cashier check, Visa, Mastercard, and Discover Card
We also offer an extended payment plan with prior credit approval

## APPOINTMENTS

Your appointments are scheduled to respect your time. We reserve a significant amount of time and a specific room for your care, and make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your reserved time. However, if you must change an appointment, **a 48 hour notice** is expected. A fee may be applied for short notice or missed appointments.

Our main purpose for having policies is to keep our patients informed of their choices and obligations. We want to serve your dental needs and handle the business aspect through a clear understanding by all parties involved. If you have any questions, we are always willing to answer them in person or by telephone.

I have read, understand, and agree to the above office and financial policies.

______________________________________ ____________________
SIGNATURE OF RESPONSIBILITY PARTY Date