RONALD L. WRIGHT, D.D.S., INC.
Diplomate, American Board of Oral and Maxillofacial Surgery
20932 Brookhurst Street, Suite 204, Huntington Beach, CA 92646
(714) 963-0727 office / (714) 963-9647 facsimile

FINANCIAL POLICY

We are dedicated to providing the best possible care and service and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions, please discuss them with a member of our staff prior to signing this form. **Please indicate, by marking the box, that you have read each paragraph.**

☐ The investment necessary to complete your treatment is an estimate based on the information gained from your examination. Should additional treatment become necessary, this estimate may be revised. If possible, you will be informed before any unexpected treatment is undertaken. The estimate, providing no changes have occurred, will be honored for a period of 90 days, from the date indicated below.

☐ Unless other arrangements have been made in advance with our office or your insurance company, full payment is due at the time of service. For your convenience, we accept VISA, MASTERCARD, AMEX and DISCOVER.

☐ As a courtesy, our office will submit your claim to your insurance carrier, provided there is a current assignment of benefits signature on file with our office. On the date of service, we ask that you pay your estimated co-payment. **If your insurance company does not remit full payment to our office within 60 days from the date of service, we will look to you for payment in full.**

☐ Once 60 days have expired and payment has not been received, by you or your insurance company, your account may also be charged interest at the rate of 1.5-% monthly, not to exceed 18% annually. A $25.00 late fee, per month, may also apply, when or until full payment is not received in our office.

☐ All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," you will be responsible for all remaining charges. **Payment is due upon request from our office or notification through your explanation of benefits provided by your insurance company.** Your insurance payment is subject to several factors, including eligibility of the patient/subscriber on the date services are rendered and annual plan maximums, limitations and deductibles. We estimate fees to the best of our ability with the information available to us regarding your coverage. This treatment estimate is, in no way, intended as a guarantee of benefits or payment from your insurance carrier. **Please be advised that insurance companies may imply coverage, yet change their implied financial obligation, without notice, in full or in part, towards your surgery. Your insurance company may also adjust your co-payment amount without prior notice, sometimes increasing your out-of-pocket expenses.**

☐ For our patients with dual insurance coverage, we regret that we can no longer bill both carriers in your behalf. Insurance companies can take in excess of 16 weeks to pay towards your claim and backlog our office with time consuming telephone calls which often include requests for duplicate x-rays and various photocopies. If you have dual insurance coverage, our office will bill your primary insurance company only. It will be your responsibility to submit for reimbursement from your second insurance carrier. If you have questions or need photocopies of your x-ray(s), our office will provide these for you for a fee of $15.00 per request / photocopy. We apologize for any inconvenience that this may cause.

☐ For all services provided in the hospital, we will bill your health plan. Depending on your particular health plan, the balance may be your responsibility and is subject to the same terms as in-house patients.

☐ The custodial parent(s) or guardian(s) are responsible for payment for all minor patients. In such case, the policies set forth herein directly apply to the custodial parent(s) or guardian(s).

☐ If you are requesting credit from our office, in other words, there is a balance owing, which is not subject to insurance payment, Ronald L. Wright, D.D.S., Inc. reserves the right to obtain a copy of your credit report. In conjunction with your application for credit, we may access your credit history as often as deemed necessary in compliance with our agreement with the credit reporting agencies. Our office is currently contracted with Experian.

☐ In order to provide the best possible care and scheduling to all our patients, please call us as early as possible if you know you will need to reschedule your appointment. We reserve the right to charge $50.00 - $125.00 for all appointments canceled without 24-hour notification. Dental implant cases are subject to different notification and different cancellation fees.

☐ Dental Implant patients are required to pay a deposit of $50% of their total bill. This deposit is due two weeks prior to surgery and is applied towards the surgery. Due to the extensive amount of equipment and time involved, **there is a non-refundable fee of $2,000.00 if the patient cancels surgery for any reason. The patient is also subject to the financial agreement on the implant fee estimate.**

I have read and understand the financial policy of Ronald L. Wright, D.D.S., Inc. and I am at least 18 years of age. I also agree to be bound by these terms and understand that such terms may be amended without prior notice.

_____ _____
Signature of patient or responsible party | please print the name of the patient

_____ _____
Signature of co-responsible party | Date