Brea Family Dental Center 903 South Brea Blvd. Brea, CA 92821 (714)529-3184

Written Financial Policy

Thank you for choosing Brea Family Dental Center. We want to make sure you understand our financial policy. Our goal is to provide you with excellent comprehensive dental care and customer service. We also want you to make a well informed decision on your future dental care.

- We will provide an estimate of dental treatment to you before any future recommended dental service is rendered. We will also make sure you understand the cost of such treatment prior to your commitment to treatment
- As a courtesy to you, we will help you estimate your dental insurance benefits and process your claims based on your most current information.
- Payment of your patient portion is required at the time of service.
- If payment is not received from your dental insurance carrier within 45 days, you will be responsible for the payment of your treatment fees and collection of your benefits directly from your insurance carrier. You will be responsible for any outstanding balance due if your dental insurance company fails to pay.
- Our office is not responsible for any changes with your dental insurance that may affect your overall out of pocket expenses. To expedite processing and ensure proper reimbursement, please update us on any changes to your address, personal information and insurance information.
- Dental treatment recommended to you is based on our professional judgment; your dental benefit plan is merely an adjunct to help finance treatment that is in your best interest.
- If your account is delinquent for more than 30 days, you will be charged a late fee of 10% of any outstanding balance per month until your balance is paid in full.
- A fee of $25 will be charged for any returned checks.
- A fee of $25 will be charged to patients who miss or cancel more than twice in a calendar year without giving us a 24 hour notice.

Payment Options:

You may choose from : *Cash, Check, All Major Credit Cards

*Payment plans -CareCredit or Chase Credit on Approved Credit

If you have any questions, please feel free to contact one of us. We will be happy to assist you.

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Patient Name (Please Print) Date

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Patient, Parent or Guardian Signature