3180 Bell Road, Suite 100
Auburn, CA 95603
530-888-9764

Financial/Office Protocol

Accepted Forms of Payment: We will provide you a treatment estimate in advance so that you can come prepared to pay your estimated patient portion the same day services are rendered. For your convenience we accept Cash, Check, Visa, MasterCard, American Express, and Discover. We also offer an extended payment plan through Care Credit for patients who qualify. (Please note: A $25 NSF fee will be charged for all returned checks.

Initial_____

Dental Insurance: Please familiarize yourself with your insurance plan and provisions and provide us with accurate and up-to-date information as necessary. As a courtesy, we will submit claims to your dental insurance company on your behalf. We will accept payments directly from your insurance company provided payment is received from them within 60 days. If payment has not been received within 60 days, we may ask that you provide assistance in dealing with your insurance company. Please remember that your benefits are a contract between you, (possibly your employer) and your insurance company; therefore, you are ultimately responsible for the total amount of your dental fees. Further, your dentist makes treatment recommendations regardless of your dental benefits, deductibles, limitations, or maximums.

Initial_____

Past Due Balance: Estimated patient portions are due the same day services are rendered. Once your insurance company has paid, there may be an additional remaining balance and it will be billed to you. We ask that you pay any remaining amount promptly. Outstanding accounts over 90 days will be assessed a monthly late fee of 1.75% of the amount due (21% per year). If financial arrangements have not been established and your account is delinquent, we reserve the right to turn your account over to a collection agency. In the event of default, I understand I am responsible for any attorney fees and court costs associated with collecting.

Initial_____

Cancellation Policy: If you are unable to keep an appointment specifically reserved for you, we request that you notify the office at least 48 hours in advance that we may have sufficient time to fill the appointment with another patient. A fee of $50 may be assessed to your account for "no-shows" and/or appointments cancelled without advanced notice.

Initial_____

My signature verifies that I understand the policies as outlined above, and any questions I have with regard to these office policies have been answered.

_____ _____

Patient Signature **Today's Date**

_____ _____

Team Member Signature **Today's Date**