*Dr. Helen H. Im, D.D.S*

*The Art of Exceptional Dentistry*

# Financial Policy

Thank you for choosing our office for you dental needs. We are committed to provide the highest quality of dental care available to all our patients and to have those services comfortably affordable, we are pleased to offer you options for payment. The following is a statement of our Financial Policy which must be reviewed and signed.

**INSURANCE**

As a courtesy, our office will submit your insurance claim on your behalf. However, you are responsible for any amount not covered by your insurance policy. If your insurance does not pay their estimated portion, any and all outstanding balance is your responsibility. *Delta Dental patients are required to pay all services up front due to Delta Dental policy of sending all payments to subscriber since Dr Im is out of network.*

**BOOKING FEE**

We reserve the right to have patients pre-pay a deposit of ½ the patient's treatment fee's in order to hold appointment for you.

**PAYMENT OPTIONS**

- Cash or Check Payment
- Visa, Master Card, American Express, Discover , Debit
- No Interest Payment Plan with Care Credit(OAC)

**MISSED APPOINTMENTS**

We require at least 48 hours cancellation for all appointments. Our policy is to charge $50 per hour for missed hygiene appointments and $100 per hour for appointments with Dr Helen Im. Please help us serve you better by keeping scheduled appointments or providing us with at least 48 hours notice.

**RETURNED CHECKS**

A $25.00 returned check fee will be billed for any returned checks.

**Thank you for understanding our Financial Policy.** We are here to assist you in any way possible. Please make your questions and concerns known to our team as our goal is to ensure that you have an outstanding experience. I have read the Financial Policy. I understand and agree that:

- **I understand that my insurance is a contract between me and my insurance company**
- **I understand that Dr Im is not in network with my insurance and authorize payment from my insurance to be paid directly to Dr Helen Im**
- **I understand that if my insurance does not pay their estimated portion, the outstanding balance is my responsibility**
- **I understand that insurance is not a guarantee of payment to my account and that I am responsible for my account balance**
- **I understand that job termination, change of employment or insurance plans will result in stopped payment from my insurance company and I am responsible for any remaining balance on my account**

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Signature of Patient/Responsible Party Date