

Bayside Endodontics
333 Gellert Blvd., Suite #242, Daly City, CA 94015
Phone: (650) 757-3636
Fax: (650) 757-1775

THE FINANCIAL POLICY

GENERAL

The following is a statement of our financial policy which will need to be read and signed prior to treatment. As a courtesy, we will complete and submit insurance forms for our patients. A written treatment plan and estimate of insurance benefits will be provided. Payment for services will be due and payable on the date of service. We accept the following forms of payment: cash, check, Visa, Mastercard, and CareCredit financing. A \$36 fee will be assessed on any returned checks.

TREATMENT FEES

I understand that any fees provided to me are estimates only. If my dental needs change, I will be notified of any change(s) in treatment.

ESTIMATED INSURANCE COVERAGE

I understand that the estimated insurance coverage provided to me is an estimate only, and not a guarantee of payment or benefits. Although treatment may be covered by insurance benefits, I understand that I am responsible for timely payment of my account and will be responsible for any charges that my insurance benefits do not cover. Further, I understand that I will be responsible for any insurance claims not paid within 60 days from the date of service. If, for any reason, this office is required to turn my account over to a collection agency, I understand that an administrative fee of \$35 will be assessed along with any applicable finance charges.

MISSED APPOINTMENTS

I understand that this office requires a minimum 48 hours advance notice of cancellation for any scheduled appointment and that a \$50 cancellation fee will be assessed if 48 hours notice is not given.

INTEREST

We reserve the right to charge interest in the amount of 18% per annum as provided by state law.

CONSENT

I have been informed of the treatment plan and associated fees.