Loretta Chee DDS

FINANCIAL POLICY

<u>BASIC POLICY:</u> Payment for services rendered is due in full at the time of service. Our office accepts cash, checks and credit cards.

<u>FOR PATIENTS WITH INSURANCE:</u> As a service to our patients, we will bill your insurance carrier, provided proper insurance information is given to us. We will also assist you in billing your secondary insurance carrier, if applicable, and in researching unpaid claims. Every effort will be made to closely **<u>estimate</u>** your co-payments and deductibles which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. Please understand that insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you.

<u>NON-COVERED CHARGES:</u> ***Any charges not paid by your insurance carrier will require payment in full at the time services or upon notice of insurance claim denial.***

<u>CANCELLATION OF APPOINTMENTS:</u> Our goal is to provide high quality of care at low cost to our patients and in fairness to other patients and the doctor, we require at least 48 hours' notice when canceling an appointment. There is a **<u>$50</u>** fee for missed appointments without 48-hour notification, which will be due and payable from you.

ASSIGNMENT OF INSURANCE BENEFITS for Patients with insurance coverage

I hereby assign all dental and/or surgical benefits, private insurance, and any other health plans, to <u>Loretta Chee DDS</u>. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read, understood and agree to the above financial policy for payment of the professional fees. I understand that I AM ULTIMATELY RESPONSIBLE FOR ALL FEES FOR SERVICES PROVIDED TO ME.
With my signature below, I assume full responsibility for all payments on services rendered.

______________________________	______________________________
Patient Signature	Doctor's Signature
______________________________	______________________________
Patient Name	Date