Jason P. Lipton, DDS, FAGD

351 North San Mateo Drive

San Mateo CA 94401

Thank you for choosing our office to provide your dental care! In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our Financial Policy. If you have any questions, please ask our front desk staff.

1. CHANGES IN PERSONAL INFORMATION: Changes in your address and contact information should be kept current with our office. If our office is unable to contact you by phone or mail, and your balance is overdue, your account may be sent to a collection agency

2. INSURANCE INFORMATION: New insurance must be provided to our office prior to an appointment. Failure to provide correct and current insurance information may result in the entire bill being your responsibility.

3. VERIFYING INSURANCE: Per patient request, we will verify your insurance coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing if there are any waiting periods for work performed. Any amounts on your treatment plans that are not covered by your insurance are your financial responsibility.

4. REQUEST FOR ADDITIONAL INFORMATION: These must be responded to promptly. Such requests may include updating insurance information or identification. Failure to provide information to our office could result in claim denial and in turn may result in the entire balance being your responsibility.

5. PAYMENTS: Payment is due at the time of the treatment. If you have insurance, your payment is due immediately after the insurance has paid. Any balances over 60 days will have a finance charge of 24% applied

6. CANCELLATION/FAILED APPOINTMENTS: We request 36 hours notice if you are cancelling an appointment. There will be a charge of $100 for cancellations made without said notice or for failed appointments. The $100 fee must be paid prior to making any further appointments.

Thank you for reading this information in full. Please sign below to acknowledge your understanding of our financial policies.

Patient or Guardian Signature: _____ Date: _____

Please print name: _____