Financial and Appointment Policy

Usual and Customary fees: While our fees are comparable to fees charged by other dentists in this are, they are not necessarily the same as what your insurance company considers as "usual and customary".

Insurance: If you are using dental insurance, please note that your benefit plan is generally a contract between your employer (or plan sponsor), and your insurance company. Your dental plan is designed to share in your dental costs and the designated percentages covered may not be equal to that portion of the actual fee charge (usual and customary).

As a courtesy to you, we will be glad to prepare and submit your insurance claims. However, any follow up after 60 days will become patient's / responsible party's responsibility. The patient/responsible party is ultimately responsible for the bill and/or any unpaid balance after insurance has paid.

Payment Policy: Payment in full is due at the time of service, unless other financial arrangements have been made prior to the date of the appointment. If you have insurance coverage, your estimated portion will be expected at the time of service. We accept cash, check, credit card payments (Visa, MasterCard, American Express, Discover), or outside financing (Care credit or Dental Fee Plan).

Returned Checks will be subject to a $45.00 returned check fee.

Appointments: Your appointment time has been reserved specifically to meet your dental needs for that visit; therefore, as a courtesy to Dr. Roxas and his staff, please give us at least 48 hours notice if you not able to keep your appointment. That will allow us enough time to give your reservation to another patient. There is a $50 fee for missed appointments
without 48 hours notice.

Treatment for minor children (under age 16): Unless other arrangements have been made prior to the appointment, the minor child's parent(s) or legal guardian must accompany the child.

I acknowledge that I am financially responsible for all charges incurred whether or not they are covered by insurance. I assign any insurance payments to be paid directly to Dr. Jonathan Roxas, which would otherwise be payable to me. I also authorize the release of any information, including diagnosis and treatment records to my insurance company.

Patient's Name:_____

Responsible Party's Name (Please print):_____

Signature:_____ Date:_____