Dimitri Grammas D.D.S.
149 E. Lincoln Ave Orange, CA 92865

Financial Policy Agreement

• **Insurance and Patient Copay** Based on your plan benefits provided by your insurance plan, there may be a copay and deductible. These costs are due at the time of your visit. A claim will be submitted to your insurance company and may take 30-60 days to process. Insurance coverage is never a guarantee of payment. In the event the treatment is not covered the patient is responsible for the cost.

• **Billing and remaining balances** Copayments are an estimate based on current insurance benefits and maximums listed by the insurance company at the time of your visit. In the event the insurance payment is greater or lesser than expected, the balance is adjusted and the patient will receive a statement or refund for the difference.

• **Self-Pay** If you do not have insurance coverage, payment for your service is collected at the time of your visit. For your convenience, if you require a payment plan, we accept Care Credit. An application can be completed at www.carecredit.com. We accept cash, checks and all major credit cards as well as HSA and FSA cards. Limitations set by the FSA and HSA accounts are the patient's responsibility. Please ensure your savings cards will cover the treatment prior to your appointment. We are not responsible for refunds requested by your health savings accounts.

• **Patient responsibility and Lab Charges** With treatment that requires lab work, It is the patient's responsibility to return to complete treatment in the time required. Delaying completion of treatment may result in additional lab costs. The patient will be responsible for these additional costs.

• **Missed and Broken Appointments** We kindly ask that you notify our office at least 24 hours prior to your visit if you are unable to make it. Broken appointments are subject to a $50.00 fee per patient scheduled.

• **Late Appointments** Due to the capacity limitations set by the CDC, we are unable to take late appointments. If you will be more than 10 minutes late to your appointment, please contact our office to reschedule.

I have read and understand the above statements.
By signing, I agree to the terms of this Financial Policy Agreement for the office of
Jim Grammas, D.D.S.

Patient's Name______________________________ **Parent's name if minor**_________________________

Signature_____________________________________ **Date**______________

❐ **Parent** ❐ **Legal Guardian** ❐ **Self**