CHERYL D. GOLDASICH, D.D.S., FAGD
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Torrance, Ca. 90505
(310) 373-9701

FINANCIAL POLICY

It is our experience that misunderstandings can be avoided by addressing financial concerns directly. If something more individually customized is needed, please feel free to discuss your situation with an administrator prior to treatment.

METHODS OF PAYMENT

1. Cash, Check or Credit Card (Visa, Master Card and Discover)
2. Dental Insurance (described below)

DENTAL INSURANCE

1. We are pleased you have dental insurance, and our office will assist you in obtaining the maximum benefits specified in you contract. However, your insurance contract is between you, your employer, and the insurance company.
2. As a courtesy to you, we will file your insurance and accept assignment of benefit. We ask that your **estimated** co-payment and deductible be **paid at the time of service**.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is not based on what is needed or necessary. Treatment you receive is your responsibility.

RELATED INFORMATION

1. Returned checks fee $25.00 and balances older than 60 days may be subject to additional collection fees and interest charges of 12% per month, and $25.00 late fee. These additional fees will be applied to the unpaid balance.
2. In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court costs, and collection agency fees).
3. Your appointment time has been reserved exclusively for you. **We do not double book. Any change in your appointment affects many patients**. **48 hours notice is needed to avoid a charge and your courtesy to others is appreciated.**

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.

Print Patient Name:_____

Print Guardian Name:_____

Signature of patient:_____ Date:_____
(Parent or Guardian if minor)