

## FINANCIAL POLICY

We would like to thank you for allowing us the privilege of being your dental health provider. We are committed to providing you with the best possible dental care. The following is a statement of our office policies regarding the Financial Policy, Missed Appointments, and Cancellations.

### OUR DENTAL BILLING PROCESS

Thank you for choosing Dr. Negari for your dental needs. To better serve you, we would like to explain the dental billing process at our office. Once you provide the office with your dental insurance we call your insurance company and verify your benefits. The information we receive from your insurance company is only an estimation of coverage and not a guarantee. After you have been seen in our office we will file your claim to the insurance company directly. If the insurance company does not cover the estimated amount in full, you will receive a statement in the mail and be responsible for the remaining account balance.

### FEES AND PAYMENTS

We make every effort to help you optimize your insurance. We will estimate your co-insurance based on the information obtained from your benefit company. At the time of your treatment, it's your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. Our office does not extend credit for dental care. Other arrangements can be discussed with our office manager before the start of treatment. An estimate of the charges for any procedure you may require will be given to you upon request.

### MISSED APPOINTMENTS/LATE CANCELLATIONS

We ask that you call our office and kindly give us at least 48 hours notice to reschedule your appointment. Appointments that are canceled with less than 24 hours notice are considered a broken appointment and may be subject to a cancellation fee of \$50 for a hygiene appointment, and \$65 per hour for appointments with Dr. Negari. Our goal is to provide treatment in a timely manner with as few visits as necessary. We make every effort to remind you of your appointment ahead of time. We understand that last minute changes in your schedule may be unavoidable and we will try to accommodate those changes as best we can.

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Patient/Parent/Guardian Name

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E-mail

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Cell

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Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date