FINANCIAL POLICY

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement.

As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer.)

Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your dental plan.

A service charge of 5% per month on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. We offer outside financing through Care Credit, and if approved, can extend payments over a course of 12 months with no interest or service charges.
_________ (Initial): I authorize iTooth Dentistry to send my account details, in accordance with California State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to a debt collector / 3rd party collections agency, on any unpaid balance on my account exceeding 90 days. I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination.

CANCELLATION & NO SHOW POLICY

We, iTooth Dentistry, understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24-hour notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24-hour notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to a **$50.00** cancellation fee. Procedure cancellations require 2-3 business day advance notice, without notification they may be subject to a **$75.00** cancellation fee.

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department (559-298-3200).

Please sign that you have read, understand, and agree to this Cancellation and No-show Policy.

Patient Name (Print): ______________________________________ **Date:**_______________________

Signature of Patient / Representative: ________________________ **Date:** ______________________