Yong & Kim Dentistry

Dental Financial Policy
Insurance Patients

The following financial policy applies to all patients who have insurance coverage. Please carefully read and sign this agreement. Let our finance staff know, if you have any questions.

1. We will be happy to bill your insurance company for your care providing you give us all the information we need. Even though you have insurance coverage, please remember that paying for your dental care is you personal responsibility.
2. You will need to pay your portion of the charges as you go. This includes the annual deductible, co-payment and charges your insurance company refuses to pay. Our office policy does not allow us to extend credit.
3. We will need to verify your insurance benefits by contacting the insurance company. We will also have you sign other forms as needed.
   Please note: until we have verified your coverage, you will be responsible for paying for your own care at each visit including the first visit. After we verify your coverage, we will credit the amount you have paid to your portion of the bill.
4. We will bill your insurance company at the time of your dental service. Payment is expected within 60 days. We will automatically transfer and bill you for any payments not received from your insurance company after 60 days. You need to pay us in full at that time. Any amounts you personally owe that are 30 days late will receive a service charge of 3% per month. All legal and collection costs incurred for collection of past due amount will be charged to the guarantor and the patient.
5. Occasionally an insurance company will send a payment to a patient. If this occurs, bring us the check and the attached stub. The information on the stub is very important.
6. Your insurance company may request additional information from you. Please send the information to them right away. They will not pay your claim until they receive the information.
7. If you suspend or terminate your care against the advice of your doctor, all outstanding charges that have not been paid by you or your insurance will become immediately due and payable by you personally before you leave.
8. **APPOINTMENT CANCELLATION POLICY**
   Please note that there will be a $ 25.00 charge for any missed appointment without a 24 hour notice.
9. **MINOR / CHILD CONSENT**
   I agree that parents/ guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.
10. **ASSIGNTMENT AND RELEASE**
    I,Undersigned, have insurance with _____
    Name of Insurance company(ies)
    And assign directly to Yong & Kim Dentistry all benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the practice to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

By signing below you agree to follow this policy.

_____

Patient / Guardian **Date**

_____

Print Name