

Encinitas Periodontics & Dental Implants Financial Policy

PATIENT PAYMENT POLICY

Patients who are covered under an insurance policy are responsible for anything that their insurance does not cover. Insurance Estimates are provided as a courtesy. In the event that your insurance carrier pays less than the estimate, you are responsible for the unpaid balance. Estimates we provide are based on the information that your insurance company has provided to us. All payments are due at time of service & all unpaid balances are subject to late charges. Payment for these services can be made by cash, check, and/or credit/debit card. If patients need to make payment arrangements for their portion they must speak to the office manager prior to the rendering of ANY services.

PAYMENT ARRANGEMENTS

For patient portions exceeding \$200 patients may contact CareCredit for 12 months of interest free financing. This service must be applied for PRIOR to services. Please ask our front office for an information booklet if you are interested in this type of financing. For patient portions less than

\$200 patients may leave a credit/debit card on file with the business office and the portion may be split over two or three months. If this option is selected a credit/debit card MUST be left on file. Services will automatically be charged to this card one time per month on the agreed upon date for the agreed upon amount. If the credit/debit card is declined a \$10 fee will be applied to the patient's account and the patient will be contacted immediately. If for any reason the patient does not make payment within 30 days of the credit/debit card being declined the account will automatically be sent to collections. Patients who have a patient portion of less than \$200 may also apply for CareCredit for 6 months of interest free financing. Green Sky Financing is also available and a brochure is on our website.

RETURNED CHECK POLICY

There will be a \$35 charge for all returned checks. Patients are also responsible for any bank charges that may be assessed. Payment for the returned check must be made with cash, money order, or cashiers check.

COLLECTION AGENCY POLICY

Services rendered must be paid within 30 days from the date of service unless financial arrangements are made PRIOR to services. (See above for payment arrangements.) This is regardless of insurance paying their estimated portion. If the account is delinquent for 90 days, a letter will be sent to the patient notifying them of our decision to send the account to collections. The patient will then have 10 days to make payment in full on the delinquent account or it will be sent to collections immediately. If the account goes to collections the patient is responsible for any fees incurred.

FAILED/SHORT-NOTICE CANCELLATION POLICY

Our office requires **48 hours notice** to either cancel or change an appointment. If you are scheduled for a surgical procedure we require **72 hours notice** to cancel or change the appointment. If proper notice is not given on the first offense the patient will be provided with a verbal warning. On the second offense the patient will be charged a non-refundable \$50 per hour fee.

REFUND POLICY

Refunds will be issued via check after all claim payments and family accounts are settled.

I have read and understand the financial policy and agree to honor the policy.



Signature

Date