OUR FINANCIAL POLICY

Thank you for choosing us as your dental healthcare provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following statement is a statement of our financial policy; which we require you to read and sign prior to any treatment. All patients must also complete our information and insurance forms before seeing the doctor. We are glad you are here and want to do our very best for you. Please ask if you have any questions about our fees, policies, or your responsibilities. It is your responsibility as a patient to notify our office of any information changes (i.e. address, name, insurance, etc.).

FULL PAYMENT IS DUE AT TIME OF SERVICE, WE ACCEPT CASH, CHECKS, VISA, AND MASTERCARD. WE ALSO OFFER CARE CREDIT. WHICH IS AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL. (For all returned checks to our office a fee of $45 will be applied).

____
Patient Initials

REGARDING INSURANCE: We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time services are provided. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information to your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract, if your insurance company has not paid your account in full within 60 days, the balance will automatically transfer to your account. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of dental and/or medical policy.

IT IS YOUR RESPONSIBILITY TO LET US KNOW OF ANY CHANGES IN A TIMELY MANNER. PLEASE DON'T ASSUME THAT WE KNOW THAT YOUR INSURANCE HAS CHANGED.

____
Patient Initials

SELF PAY ACCOUNTS: Self-pay accounts are patients without insurance coverage or patients without insurance information on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with the information provided by the patient, the patient will be considered self-pay until the correct information is provided. self -pay patients will be required to make payments in full at time of services.

____
Patient Initials

Payment plans: Dr. Joo's office has partnered with several financial companies including Care Credit. We offer 0% interest fee financing for 6 months with any walkout over $200.00

____
Patient Initials

MISSED APPOINTMENTS/ No Show Appointment Policy

Please be advised, our office **REQUIRES** confirmation for your dental appointments. We will attempt to reach you via Phone or Text to confirm your appointment. If we do not hear from you to **CONFIRM** your dental appointment by 2pm the prior business day, then your appointment will be removed from our schedule to accommodate another patient in need of dental care.

If you need to **Cancel or Reschedule** your appointment we REQUIRE a **48-hour** notice. Please understand that missed appointment times are valuable to those patients that may find it hard to come to the dentist at other times. If you fail to give adequate notice or do not show for your appointment, or cancel your appointment within 48 hours, a fee will apply of **$75, $30** for orthodontic appointments , and **$50** for a Hygiene appointment. All of which **must** be paid before your next appointment is **SCHEDULED**. After 3 NO SHOWS/MISSED Appointments you will be dismissed as a patient by our practice. We appreciate your understanding of our policy.

____
Patient Initials

OUTSTANDING BALANCES: We try to estimate your insurance co-pays and deductibles to the best of our knowledge with the insurance information we have; however sometimes the claims will settle differently. If the claim settles stating you owe more than what we had figured out we will mail you a statement with a copy of your EOB attached. Once you receive your bill you have 30 days to pay in full; if you cannot pay in full please contact our office for further arrangements. After 90 days unpaid we will send your account to collections, adding a $75 processing fee. **REFUND:** If a refund is due to you for overpayment we will send out a check after all open claims have settled.

____
Patient Initials

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I ____ have thoroughly read,

PRINT Patient/Parent or Guardian Name

understand, and agree to the financial policy.

X____ Date________________

Patient/ Parent or Guardian Signature