Patient Financial Agreement

Dear Patient,
This agreement sets forth our office financial policy.

I understand that as a recipient of dental care, I, the undersigned, am responsible for all charges regardless of my circumstances of reimbursement**. Payment is due on the date of service.** I understand that a fee is charged for all visits, examinations, or radiographs taken. I agree that the determination of the professional services to be rendered by my doctor and the fees to compensate her for these services are matters that concern my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for her services, not withstanding any contract that I have with any third party payor(for example, insurance company, employer, etc.)

I hereby authorize the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on my behalf and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my doctor and all necessary parties to submit claims to obtain benefits for services rendered without obtaining my signature for each and every claim to be submitted for myself and my dependents. I will be bound by this signature as if the undersigned had personally signed that particular claim.

I understand that any unpaid charges are my responsibility. Patient balances are due immediately and are not contingent on receiving a statement. Insurance companies provide an explanation of benefits outlining payment and patient balances.

I understand that there is a 10% finance charge for all care credit transactions. This fee is due on the date of service. Unpaid charges over 60 days may incur a monthly service charge of $25. Accounts with no activity for 90 days may be forwarded for further collection action. If I default and my account is referred to a collection agency or attorney I will be responsible for all costs of collecting the monies owed, including interest, court costs, collection, collection fees, and attorney fees. Any and all advance collection fees incurred by the practice will be included in my final bill.

I understand and agree that some additional charges may occur from my treatments that are not included in the initial estimated bill. I understand and agree that any such additional charges are my responsibility. Should my insurance cover all services, the money will be refunded upon final insurance payment. There is a $25 charge for all returned check.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:
_____ 1. Providing Dr. Anna Lu, DMD with complete and accurate billing information, including, but not limited to a current insurance information, authorization numbers, and/or referral forms for each visit and/or procedure. I am responsible for all visits and procedures.

_____2. I will pay all applicable co-pays and outstanding patient balances as they become due. All copays and patient balances are due at each visit unless other arrangements have been made.

I have read and agree to the terms outlined above.

Signature_____Date_____

Print_____