Duane Fong, D.D.S.

Cosmetic and Family Dentistry

A PROFESSIONAL CORPORATION

Patient Financial Policy

It is customary that payment is due on the day that services are rendered. You will be given an estimate of the costs.

If you are a member of a Dental Insurance Plan and have chosen us as a provider, it is your responsibility to:

- Provide us with information relative to your claim, including insurance card, ID number/group number, claims mailing address, employer, name of insured, date of birth, address and Social Security number.
- Pay your deductible or co-pay at the time of service unless other arrangements have been made.
- Patients should be aware that some insurance companies only pay claim percentages based on their evaluation of what is "usual and customary" and not on our fee schedule.
- After we have received payment from your insurance company, any refund will be mailed to you or if there is any outstanding account balances you will receive a statement.
- It is impossible for us to know what individual policies will allow as policies are handed out to the subscriber and the employer. Not the dental offices.

Remember, your insurance plan is a contract between your employer and the insurance company. Benefits depend solely on what the purchaser (employer) wishes to offer. Some plans cover as little as 30% or as much as 100% of covered services with most falling in the 50% to 80% range. The insurance company is responsible to the patient. Specific questions should be directed to your insurance carrier or your employer. All patients are financially responsible for their accounts.

Insurance claims for your carriers are filed as a courtesy at no charge to you.

- To assist you with your payment, our office accepts Cash, Check, Visa, Mastercard, Discover, American Express and Care Credit.
- A $25. overdraft charge will be posted to your account for each insufficient check.

I have read this agreement and fully understand its content. I understand that I am responsible for all charges regardless of my insurance coverage.

_____ _____

Patient or responsible party's signature. Date

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