PACIFIC BEACH DENTISTRY - OFFICE POLICY

PAYMENT

Pacific Beach Dentistry requires my payment portion at the time treatment is rendered. This includes any deductible, co-payment, or previous balance. Acceptable forms of payment include Visa, MasterCard, American Express, Discover, Cash and Personal Check. Monthly payment plans are available through CareCredit. Overpayments will be refunded upon written request to the responsible party within 30 days. Otherwise, it will remain as a credit on my account.

INSURANCE

I understand that Pacific Beach Dentistry will make every effort possible to assist me with my insurance coverage. The office allows no more than 90 days for insurance to submit payment. Any outstanding claims past the 90-day mark will be my responsibility. If the insurance submits a payment following the deadline, the office will reimburse me or credit my account. It is my responsibility to pay any balance not covered by my insurance.

RETURNED CHECKS

A **$25** service fee will be charged for each NSF check received by Pacific Beach Dentistry and personal checks will no longer be an acceptable form of payment.

CANCELLATIONS

I understand that should I need to cancel an appointment time reserved specifically for me, I will notify Pacific Beach Dentistry at least 24 hours in advance so that my time may be utilized by another patient. If I fail to give a minimum of 24 hours notice, I will be required to pay a fee of **$50** per scheduled hour before a new appointment time will be made for me. Excessive abuse of missed appointments may result in discharge from the practice.

ACCURATE PATIENT INFORMATION

I understand that I need to provide Pacific Beach Dentistry with my most current and updated personal information at every visit. This includes, but is not limited to name changes, addresses, phone numbers, employer changes, insurance plan changes, and medical health updates. I will be required to pay a **$25** fee for re-submission of insurance claims or returned mail due to incorrect information in my file.

COLLECTIONS

I understand that should my past due account need to be turned over to a collection agency, all collection costs, fees, and interest will be added to my balance.

X_____

Patient Signature Date

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Print Name