Alan P Chun, D·D·S·, M·D·, Inc·
A Professional Corporation
Oral & Maxillofacial Surgery
9301 Fircrest Lane ▪ Suite 6 ▪ San Ramon, CA 94583 ▪ Phone: 925-833-8516 ▪ Fax: 925-833-8347
Fellow of American Association of Oral & Maxillofacial Surgeons
Diplomate of the American Board of Oral & Maxillofacial Surgery

FINANCIAL POLICY

Dear Patient:

Thank you for selecting us as your dental health care provider. The following information describes our Financial Policy. Our primary goal is that you receive optimal treatments needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask one of our front office managers.

Payment for services is due at the time services are rendered. We accept cash, personal checks, and for your convenience MasterCard and Visa. We will help you process your insurance claim for your reimbursement as long as we have complete insurance information provided at your consult appointment.

There will be a <u>Cancellation fee</u> charged of $200.00 for surgical appointments if 48 business hours (Monday-Friday Not Weekends) notice is not given or you cancel and reschedule 2 or more times.

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company. It is best you understand your Insurance Maximum per your policy's calendar year.

2. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. A Predetermination, which is a submission of your treatment plan to your insurance carrier, can be sent for approval before treatment begins.

   Would you like our office to send a Predetermination of Benefits? _____YES _____NO
   DATE: _____. Please understand that this process can take 4-6 weeks and is not a guarantee of payments.

4. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.

5. As the patient you receive an Explanation of Benefits from your insurance company. If the insurance company does not pay in full within 45 days, we will require you to pay the balance due with cash, check, MasterCard, or Visa.

6. Balances older than 60 days will be subjected to Late Payment Charges of 1 ½ % per month (18% A.P.R., minimum of $1.00).

7. Returned Checks will have an additional fee of $25.00 added to the amount of the returned check.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account.

Again, thank you for choosing Dr. Chun as your health care provider. We appreciate your confidence in us and the opportunity to serve you.

Patient's or Guardian's Signature: _____ Date: _____