FINANCIAL POLICY

CHRISTOPHER A. JORDAN, D.D.S. & CAMTU N. PHAM, D.D.S.
General & Cosmetic Dentistry

Financial Agreement

Payment for services rendered are due at the time of service. If you have insurance coverage, it is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance policy. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

As a courtesy, we will attempt to confirm your insurance coverage prior to your treatment. If we have a contract with your insurance company, we will provide an estimate of your deductibles and copayments, based on any information given to us by you or your insurance company. In addition, we will submit an insurance claim for the services you receive on your behalf. Any estimated patient portions are due at the time of service. Any amounts unpaid by your insurance company will be billed to you. If the amount that is paid by insurance is more than our fee, a refund or a credit will be issued to you.

Some insurance plans provide out-of-network benefits that may be different from in-network benefits. If you receive services as part of an out-of -network benefit, your portion of financial responsibility may be higher than the in-network rate. We do not render our services on the basis that your insurance company will pay our entire fee.

Missed Appointments

No charge will be made for rescheduling an appointment provided at least 48 hours notice is given. Otherwise, a minimum charge of $50.00 per missed appointment may be incurred.

Service Charges

Please be advised that the policy of this office is that an interest rate of 1.5% per month (18% annual rate) will be applied to all accounts over 30 days. There will be a $25.00 handling fee for each returned check.

Collection Fees

In the event that your account becomes delinquent, all costs of any collection proceedings will be the responsibility of the patient or responsible party. Initiation of treatment implied consent as outlined in this agreement.

Communications

_____ I consent to the dental practice using my cell phone number to call and/ or text regarding appointments, treatment, insurance, my account, and special promotions. I understand that I can withdraw my consent at any time. My cell phone number is (_____)_____-_____.

_____ I consent to receiving from the dental practice email communications regarding treatment, insurance, my account, and special promotions. I understand that I can withdraw my consent at any time.
My email address is: _____@_____.

Financial Consent

I, _____, the patient (parent/guardian if patient is a minor), agree to be responsible for full payment for procedures performed in this office. This includes any treatment or amount not paid by my dental insurance. I certify that I have read, understood, and agree to the contents of this document. I have received a copy of this document.

_____ _____

Patient's Signature (Parent/Guardian if patient is a minor) Date

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