FINANCIAL POLICY

I understand that Dr. Ida's office will bill my dental insurance solely as a courtesy. I understand that I am financially responsible for all fees incurred in this office.

I acknowledge that prior to obtaining my consent for treatment, Dr. Ida's office reviewed my insurance eligibility & benefits and have addressed all my questions regarding my dental benefits. I also understand that the amount quoted to me as the dental insurance benefit and my co-payment are an **ESTIMATE** only and does not guarantee actual payment by the insurance. I understand that Dr. Ida's office cannot guarantee payment since the dental insurance companies will not guarantee payment until the actual claim is processed after the treatment. I accept financial responsibility for ALL charges not covered by my insurance benefit.

I understand that if the insurance company pays less than the estimated amount discussed at the treatment time, I agree to pay the remaining balance immediately when the first statement is sent to me. If my insurance carrier does not remit payment to Dr. Ida's office within 60 days of the treatment, I agree to pay the full balance owed at that time. If an insurance payment is received after my full payment, I understand that a refund check will be sent to me in the appropriate amount.

In the event that my insurance company requests a refund of payments made to Dr. Ida's office for any reason, I understand that I may be responsible for the amount of money refunded to my insurance company. If my insurance company makes a payment directly to me, I recognize an obligation to promptly remit the payment(s) to Dr. Ida's office.

If formal collection procedures become necessary I understand I will be responsible for additional costs incurred. Your portion is estimated at the time of service and is due and payable when services are rendered.

CANCELLATION AND NO-SHOW POLICY

This office requires a 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is $250 for treatment appointment and $ 50 for evaluation appointment.. This charge WILL NOT be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment in this office.

NOTICE OF PRIVACY PRACTICES

A copy of the privacy act is posted in our waiting room; please take the time to read it. If you wish to have a copy, please ask the receptionist to make a copy for you.

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SIGNATURE **DATE**