ELBERT CHANG, DDS, MS
Rockville Perio, PA • 5830 Hubbard Drive, Rockville, MD 20852 • (301) 881-4867
Practice Limited to Periodontology & Dental Implants

FINANCIAL POLICY

Thank you for selecting us as your dental care provider. The following information describes our financial policy. Our primary goal is that you receive the optimal treatment 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 staff members.

Payments for services rendered are due at time of treatment. We accept cash, personal checks, Visa, MasterCard, and Discover. We will help you process your insurance claim for your reimbursement as long as we have all of your insurance information. **You will be required to pay, at the time of service, the portion of the service that we estimate will not be paid by the insurance company (unless other arrangements are made ahead of time).**

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract (with the exception of some dental PPO insurances). Our financial relationship is with you, not your insurance company.

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

3. Fees for these services, along with unpaid deductibles and co-payments, are due at time of treatment. **We will collect the expected patient portion at the time of service.**

4. If the insurance company does not pay your balance in full within 30 days, we will ask that you contact the carrier to assist with payment in a timely fashion.

5. If the insurance company does not pay in full within 60 days, we will require you to pay the balance in full with cash, personal check, Visa, MasterCard, or Discover.

6. Balance older than 30 days will be subject to interest charges of 1.5% per month. Returned checks will have additional fee of $35.00 added to the amount of the returned check.

7. If it becomes necessary, at our discretion, to turn an overdue balance over to collection, you will be responsible for costs of collection (33 1/3% of balance), in addition to court costs and attorney's fees actually incurred in the collection of your account.

8. If a statement has been sent and the account is not paid prior to the next billing cycle, at $25.00 rebilling fee will be charged.

Cancellations: Please note that, unless we are notified at least 48 hours in advance, you will be charged $50 for a cancelled visit. For Monday appointments, we request notification prior to the close of business on Thursday. Please call the office as soon as possible if you have to reschedule. Cancellations affect many people including you (your dental health), the doctor and staff, and the patient(s) who could have been scheduled; they also increase the cost of care. _____(Initials)

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 our office as your dental care provider. We appreciate your confidence and the opportunity to serve you.

NAME (print) _____

SIGNATURE _____DATE _____

Please let us know if you would like a copy of our financial statement. last updated: April 2011