

financial policy

We are committed to providing you with the highest quality of endodontic care utilizing only the best materials and education available. In our process of doing so, we have formulated a financial policy to continue to provide excellent service for you and minimize our administrative costs.

As a condition of treatment by this practice, financial arrangements must be made in advance. This practice depends upon reimbursement from the patients for the costs incurred during their care and the financial responsibility on the part of each patient must be determined before treatment.

Payment in full is due at the time service is provided. Any dental services performed without prior financial arrangements must be paid in full at time of treatment. For your convenience, we accept the following methods of payment:

- **Cash**
- **Credit Cards** (Visa, MasterCard, Debit and American Express)
- **Care Credit with up to *12 months of no interest** (*Available upon request pending approved credit)

Insurance

As a courtesy to you, we will attempt to process your insurance claim for you. We try our best in good faith to determine your insurance coverage and benefits so that we may give you the best estimate of your coverage. However, this estimate is in no way a guarantee of coverage by your insurance plan and you will be solely responsible for the total amount should your insurance not pay the expected portion.

Please understand that we are a third party to your insurance plan, therefore we are not responsible for your coverage and benefits in any way.

Your insurance company has 30 days to pay your claim, should they not pay your claim within 30 days, you will be responsible of the total amount. You will be notified by mail from our office regarding your balance and you will have 7 business days to pay the amount in full.

Cancellation Policy

Please be advised that we strive to deliver the utmost excellent endodontic care possible, therefore our schedule is designed to accommodate you and a specific time is reserved for your treatment. We require a 48 hour cancellation notification in order to contact our waiting list. This is done to help accommodate other people needing to see the doctor sooner than their scheduled appointment allows. Thank you in advance for your consideration on this. Should you fail to notify us by phone in at least 48 hours of your cancellation request, you may be subject to a \$150 fee.

Account Policy

You have 7 business days to pay your balance from the time of your statement being mailed. Should your account not be paid in full, a finance charge of 1.5% of your total balance will be added per month by our discretion. Should your account not be paid within 30 business days, it will be considered delinquent and sent to collection.

By signing this policy you authorize this office to contact you via phone, cell phone, text and/or email regarding insurance dental benefits and financial arrangements.

I have read, understood and agree to the above terms and agreements of your office policy. All my questions and concerns have been answered regarding this policy.

SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF MINOR)

DATE

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