ROBIN Y. KWON, D.D.S., L.L.C
FINANCIAL POLICY FOR THE OFFICE

In the interest of good health care practice, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good dental health and we wish to spend our time and energy toward that end.

All Accounts are due and payable at the time of your visit including insurance out-of-pocket and co-payments. There is a 10% senior citizen discount with payment on date of service and a 5% to non senior patients. Visa, MasterCard, and Debit Cards are accepted. Since PPO and PDP insurance plans dental plans already give a discount, there is not an additional courtesy.

Any balance outstanding more than 60 days will bear interest at 18% per annum or 1.5% per month.

Insurance is gladly billed as a courtesy to our patients, when you provide us with current information. Even though you may have insurance pending, you will receive a monthly statement for the outstanding balance on your account. We cannot accept responsibility for collecting an insurance claim after 90 days or for negotiating a disputed claim. Insurance reimbursement is a contract between you, your employer, and your insurance carrier. You are responsible for payment of your account. If I have insurance I authorize payments to be made to Dr. Kwon.

Appointments cancelled or rescheduled with less than **48** hours notice will result in a missed appointment fee equal to half the amount of the appointment missed or $50 whichever is greater. We will not reschedule any patient after two missed appointments. Our time must be used efficiently as possible to keep our expenses down to a minimum and our fees within reasonable limits.

I have read this credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts may be assigned to a credit reporting collection service. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all cost and expenses, including reasonable attorney fees.

Patient Name _____

Signature_____ Date _____