Alex H. Kang, DDS, MSD
PROSTHODONTICS

FINANCIAL POLICY AND AGREEMENT

Outstanding Patient Service is Our Goal
The goal of Dr. Alex Kang and staff is to make sure that you receive the highest quality dental care and service. One step is to make certain that our financial policies are clear and understood by you.

Insurance – We go the Extra Mile
Regardless of your insurance policy, we will do our best to provide a good faith estimate of your benefits and all dental treatment in our clinic. In addition, we will file all the necessary claim forms (including radiographs, chart notes, etc.) and track outstanding claim(s) with your insurance company on your behalf without additional charge to you.

If your dental and/or medical insurance denies coverage, or if we otherwise do not receive payment, the amount will then become due and payable by you.

The complexity of your dental treatment may require additional surgical and/or restorative procedures to provide and meet the standard of care in our clinic, and to obtain optimal outcome of the treatment. Your insurance company may or may not approve and/or reimburse the fees associated with necessary dental procedures. Regardless of your insurance coverage, the fees associated with additional procedures are your responsibility. It is our clinic's policy to provide you with an accurate estimate of the treatment, always in advance for your review.

Based on the complexity of your dental treatment, we will honor Preferred Provider Fees (PPO) up to your maximum dental benefit but requires fee for service on the remainder of the procedures/dental treatment. Your insurance coverage is a contract between you and your insurer and/or your employer and your insurer. Although we will make every effort to help you obtain your benefits, we cannot force your insurer to pay.

Your Payment is Due at the Time of Treatment
The estimated patient portion is due on the day services are rendered. If multiple appointments are required, payment is due at the first appointment. Any other arrangements **MUST** be made prior to the date of service. All payments made by **Credit Card/Debit Card** will receive a **2.5%** surcharge.

Patient Responsibility
I acknowledge my responsibility for payment of the services received from Alex H. Kang DDS, MSD in accordance with their regular fees and terms.

I understand my responsibility is not modified by whether any third party (insurance) pays for all, part or none of the charges. I understand that this account becomes delinquent if not paid within 60 days after billing and that at that time a finance charge of 1.5% of unpaid balance will be charged every month until the balance is paid in full.

Cancellation Policy
We understand sometimes circumstances arise that may prevent patients from keeping appointments. However, we ask that you give us a minimum of 48 hours notice if you need to make any type of appointment change. This allows us the opportunity to give another patient this valuable time with one of our dental care providers. In some cases a fee may be assessed when ample notice is not given for missed or changed appointments.

Assignment and Release
I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance and I authorize release of any medical care information requested by my insurance carrier.

Patient Signature:_____ **Date**_____