

Financial Policy

Thank you for choosing *Kamran Kashirad, DDS* as your dental health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE

We accept: CareCredit, Visa, MasterCard, Discover and Cash

Regarding insurance:

We will accept assignment of benefits, however, please understand that your dental insurance is a contract between you and your employer/insurance carrier. The account balance is your responsibility whether your insurance company reduces the estimated payment or denies your claim. If your insurance company has not paid in full within 45 days, the balance will be automatically transferred to patient portion due. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance plan.

Usual & Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents/guardian are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover or Cash payment at time of service has been verified.

Missed Appointments

Unless canceled at least **48 business hours in advance**, our policy is to charge for missed appointments at the rate of **\$50** per hour failed. Please help us serve you better by keeping scheduled appointments, or providing the appropriate notice.

Interest

We reserve the right to charge interest in the amount of 18% as provided by state law.

Collections

In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to this Financial Policy.

X _____
Signature of Patient or Responsible Party

Date: _____