# FINANCIAL POLICY

SELECTIVE DENTAL
3151 S. WHITE RD., SUITE 203
SAN JOSE, CA 95148
Office: 1-408-238-7646 Fax: 1-408-238-8096
Email: contact@selectivedentalsanjose.com

We are committed to providing you with the best possible care. If you have dental insurance, we will be happy to help you receive maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our payment policy. Estimate patient payments are due when services are rendered. We will be happy to bill your insurance claim as a courtesy to you. However, any insurance claims not paid within 60 days from the date billed will become your responsibility. All accounts 30 days or older will be assessed a finance charge of 21% annually or 1.75% monthly. You will receive a statement regarding your account on a monthly basis. In order to ensure proper claim submission, you must notify us of your current insurance on or before the day of treatment. **You will be responsible for a $35.00 return fee for any check returned for insufficient funds**. We will gladly discuss your proposed treatment and answer any questions relating to your insurance or account. You must realize however,

- Your insurance is a contract between you and your insurance company. We are not a party to that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they do not cover.

We must emphasize that as health care providers, our relationship is with you NOT **YOUR INSURANCE COMPANY**. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately your responsibility. We do not have a relationship with any FSA or HSA accounts. As a courtesy we can provide a copy of your ledger of your account to turn into your FSA or HAS account. Communication can often avoid problems. We encourage you to contact us if you have any questions or any uncertainties, please do not hesitate to ask anyone on our team. We are here to help you!

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I have read and understand the above financial policy. I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but are not limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 60 days after being billed by the dentist. Additionally, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or attorney to whom an unpaid account balance has been assigned or referred (a) by mail at any address that I provide to the dental office and/or (b) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Signed: _____ Date: _____
*Patient or Legal Authorized Representative*

Name: _____ Relationship: _____
*If Signed on Behalf of the Patient*

**Thank you for choosing our office!**