LeJon M. Carreon, D.D.S.
FAMILY DENTISTRY

OFFICE FINANCIAL POLICY

PAYMENT

Your estimated patient payment in full is due at the time of service unless prior financial arrangements are made. For your convenience, we offer several payment options.

1. Cash or check
2. Visa, MasterCard, Discover, American Express
3. Care Credit (no interest / monthly payment options / subject to credit approval).

INSURANCE

Our office is committed to helping patients maximize their dental benefits. Please remember, your insurance policy is a contract between you and your insurance company. You are ultimately responsible for any balance not paid by your insurance company. Insurance contracts vary greatly and therefore, we can only offer a good faith estimate, not guarantee coverage. The estimated patient portion must be paid at the time of service. As a courtesy to our patients, we will send a claim to your insurance company as well as appeal denied services if necessary, please feel free to talk with our staff regarding any questions.

MINORS

Payment for services for the treatment of minors is the responsibility of the adult accompanying the minor to the appointment.

CANCELLED/RESCHEDULED/MISSED APPOINTMENTS

Once an appointment has been made, please remember that this time has been reserved specifically for you. We ask that a minimum of 48 hours be given if you will be unable to keep your appointment. This courtesy on your part will make it possible to schedule another patient waiting for treatment. Dr. Carreon reserves the right to charge a $50 broken appointment fee for appointments that are cancelled or rescheduled without adequate notice.

SERVICE CHARGES

A finance charge may be imposed on those charges not paid in full within 30 days. The finance charge is 2% OR $2.00 per month WHICHEVER IS GREATER. If your payment is not received by the due date, you may be assessed a late payment charge. The late payment charge will be $5.00 or 5% of the past due amount, whichever is greater.

COLLECTION FEES

Fees incurred to collect payment will be billed to and payable by the patient's account holder.

I, _____, have read, understand and agree to the above financial policy. I understand that I am fully responsible for the fees of services rendered, regardless of any insurance I may have.

Signature of patient/responsible party Date