Anh N. Le, D.D.S.
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Financial Agreement

Thank you for choosing us as your dental care provider. We are committed to providing you with the best dental care possible. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered: Fees for non-covered services, along with deductibles, and co-payments are due at the time of treatment. We gladly accept cash, checks, Visa, Mastercard, and Discover.

Cancellations: We reserve the right to charge a **$50.00** fee for appointments cancelled or broken without 24-hour notice. In addition, we also reserve the right to terminate treatment of any patient when scheduled appointments are not kept. **Patients may be required to provide credit card information to be kept on file when rescheduling any appointments that have been previously missed.**

Dental Insurance: As a courtesy, we will file your claims and accept assignment of dental insurance benefits provided that you agree to the following:

- You must provide us with an insurance card and all necessary information to verify coverage for you and your dependents.
- Your insurance is a contract **between you, your employer, and the insurance company**. We are **not** a party to that agreement and are **not** responsible for what they will **not** cover.
- Although we may estimate your insurance benefits, we are not responsible for their accuracy. Knowledge of benefits, as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely **your** responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of your original estimate.
- Any charges that have not been paid after 90 days will automatically be due and payable by you. Any payments received from the insurance company after that date will be applied to your account, with any over-payment refunded to you.
- After dental insurance has paid its portion, a statement will be sent to the patient for any remaining balance. Payment is expected within **30 days** of the statement date to avoid additional charges or collections.

I have read and understand the above information and will take responsibility in making sure that the services rendered to me are paid in full.

Signature of Patient or Guardian: _____ Date: _____