Dr. Kyu J. Lee, DMD, PC
Dr. Chitti Mengji, DDS
Dr. Shilpi Gupta, DDS

DENTAL FINANCIAL POLICY & AGREEMENT

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care. Our philosophy in serving people is to be informative, honest and forthright. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement, please do not hesitate to ask our business office staff.

PAYMENT

Payment in full is due at the time of service unless prior financial arrangements are made. We offer several payment options:

- CASH
- Credit/Debit Card (Visa/Master)
- Cashier Check

***We no longer accept Personal Check.**

INSURANCE

All patients are responsible for payment for all dental services completed. Patients who have dental insurance should understand that the charges for all dental services furnished are patients' responsibility as well. Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will be happy to manage all claim submission and follow up on your behalf. If you have any questions, our courteous staff is always available to answer them.

MINORS

Payment for services for the treatment of minors can be made by cash or credit card and is the responsibility of the adult accompanying that minor.

FINANCE CHARGES AND COLLECTION FEES

Finance charges will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVERDUE BALANCE

An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

FINANCIAL CONSENT

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement

PATIENT NAME: _____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____

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Appointment Cancellation Policy

We understand that unplanned issues can come up and that you may need to cancel an appointment. If that happens, we ask that you call or text at least 24 hours in advance.
Our providers/ hygienists want to be available for your dental needs. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen.
Although we have discussed cancellation policies, circumstances have caused us to enforce a policy to charge for no-show appointments and appointments cancelled within 24 hours.

Effective immediately, there will be a fee of $25.00 per 30 minutes if we do not receive a call or text to cancel an appointment.

We thank you in advance for your cooperation and understanding.

PATIENT NAME: _____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____

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