LOMA LINDA UNIVERSITY

Center for Dentistry and Orthodontics/Faculty Dental Practices

159 West Hospitality Lane

San Bernardino, CA 92408

(909) 558-4960 Fax (909) 558-0689

Office Financial Policy With Risk Insurance

- **This notice confirms that you are aware that your dental provider accepts Risk Management Insurance. We request that you carefully read your policy to be sure that you are fully aware of any restrictions that may apply to the benefits provided by your insurance company. Dental insurance is a contract between the patient and the insurance company for reimbursing the cost of dental services. It is not a contract between the dentist and the insurance company. We will collect your initial estimated portion and then bill Risk Management for the treatment. You will be responsible for any outstanding balance following insurance reimbursement. Financial arrangements must be established before our office can proceed with your doctor's recommended treatment.**

- **All patients who are seen in our office for a Comprehensive Oral Exam are provided with a Treatment Plan. This is an ESTIMATE of the anticipated cost of your dental treatment. Your Treatment Plan will include an estimated insurance payment based on your dental coverage. If your carrier's payment differs from our estimate, you are responsible for the balance. In the case of an overpayment, you are entitled to a prompt refund. Any claims over 90 days, become your responsibility.**

- **If after insurance pays, there remains a balance on your account, you will receive an *Account Statement*. This is due and payable by the end of the month. We will continue to send a statement each month until the balance of your account is paid in full. Should your account become delinquent (past due), we will continue to send a statement until the balance is 90 days old. If your account remains delinquent, two consecutive letters will be sent in order to avoid the necessity of pursuing further collection actions. Should your account remain delinquent, we will forward the balance to our collections department.**

- **Cancellation Policy: If it becomes necessary to reschedule your appointment, we request the courtesy of 24 hours notice. If you cancel, do not show or miss your appointment without the required notice we will assess a $75.00 non-refundable missed appointment service charge. This fee is strictly enforced and will not be covered by your insurance.**

- **If you have any questions regarding your account balance or if you are experiencing circumstances beyond your control, please contact our office. We will be happy to assist you with your questions or to set up special payment arrangements.**

Our practice firmly believes that a good doctor/patient relationship is based upon a clear understanding of office policies and an open line of communication. We have instructed our staff to make every effort to clarify any misunderstandings you may have concerning your account balance or our financial policies. We hope to avoid any possible disagreements over payment for professional services. Our patients and our relationships with our patients are very important to us. If you have any questions or need assistance, please contact us immediately.

Patient Signature:_____ **Date:**_____