Dr. James C. Ma DDS
FAMILY DENTIST AND ORTHODONTICS

Financial Policies

In order to enhance communication and promote understanding regarding this office's Financial Policies, please read through the following information. After reading, please provide your signature at the bottom indicating that you full understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please ask a staff member. Thank You!

_____**No Shows/Missed/Rescheduled Appointments:** It is important for patients to keep their scheduled appointment, because broken appointments result in lost time that could have been used to treat other patients. We request notice to cancel or reschedule an appointment of at least 24hrs prior to the appointment scheduled. If appropriate notice is not given a charge of ***$75.00*** will be assessed to the patient's account. If you are more than 10 minutes late for an appointment, you may be asked to be rescheduled if there is not enough time to complete your procedure. It is not fair to our other patients to keep them waiting.

_____**Insurance:** We are happy to bill both primary and secondary insurances as a ***courtesy*** for our patients. It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portions due; however, if the insurance company does not pay the full amount anticipated, the patient is responsible for the difference and/or the full amount. Payment would be expected within 30 days of receiving statement.

_____**Patient Payment:** The patient portion due for services rendered is expected at the time of service. We accept cash, checks and all major credit cards.

_____**Financing:** We have a financing option available through CareCredit. If you have an interest in this option, please consult with one of our staff members.

_____**Refunds for Unfinished Treatment:** If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the Office Manager.

_____**Collections:** On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collection agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorney fees, and any other costs that may be incurred to enforce collection of any amount outstanding.

Patient Name: _____

Patient/Responsible Party Signature: _____Date: _____