# Dental Arts San Diego

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El Cajon, CA 92020
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**Repayment/Financial Options:**

Payment is expected at the time services are rendered. As a courtesy to our patients we will verify your dental benefits, monthly eligibility and submit your dental claims on your behalf and/or final insurance payments. You the patient or responsible party, are responsible for all amounts not covered by your dental insurance carrier. It is also your responsibility to ensure your dental insurance carrier has paid on the submitted claim (s). Typically the payment is received from the insurance company within 4 to 6 weeks after submission. If you do not receive notification from your insurance company on their action on the claim(s) submitted within the time periods, you may want to contact them to check payment status on the outstanding dental claims. In the event your insurance company does not pay at all or the required amount we reserve the right to then charge you the patient and/or your responsible party. We also inform you that the refusal to pay co-payments or fees in the determined period of time could result in your debt information being sent to a collection company. This may add finance charges, collection cost and/or possible attorney fees.

If prior arrangements have been made for the payment of services in advance of their commencement the patient or responsible party is entitled to a refund in full if such services have not commenced. The patient or responsible party is responsible for notifying us so that we can issue the refund. If the treatment plan has been agreed to, dental services have commenced, and payments received in advance and subsequently withdraws from completing the remaining agreed upon and paid for services within 10 days of commencement date the patient or responsible party will be liable for the amount of time expended by the attending Dentist and other operating costs/expenses providing such services at the rate of $350 an hour (billed in quarter of an hour increments), and those lab fees which were incurred up through date of withdrawal. We will provide you with an itemized invoice accounting for time and expenses. We will retain the amount of fees due from the amount paid in advance. The balance of the amount paid in advance for dental services will be refunded to the patient or responsible party.

If the treatment plan has been agreed to, dental services have commenced, and payment received in advance, and subsequently withdraws from completing the remaining agreed upon and paid for services more than 10 days after the commencement date, the patient or responsible party will be liable for the pro-rata portion of the services completed as of the date of withdrawal. We will retain the amount due for the services completed from the amount paid in advance. The balance of services paid for in advance, but not rendered, shall be refunded to the patient or responsible party.

**Signature of Patient**_____ **Date**_____

**Signature of Parent/Guardian if Patient is a Minor**_____ **Date**_____