Lansdowne Dental Care
Tracey Nguyen, D.D.S., F.A.G.D., A.A.A.C.D.

FINANCIAL OPTIONS

Our commitment is to provide quality dental care to the entire family through Exceptional service and the utilization of advanced technology

METHODS OF PAYMENT

1. Cash, Check or Debit Card
2. Credit Card (a 3% surcharge applies)
3. Dental Insurance (described below)
4. ACH Payments
5. Cherry Payment Plan Financing

DENTAL INSURANCE (where applicable)

1. We are pleased you have dental insurance, and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company. We will need you to bring us a copy of your benefit booklet if you would like help interpreting your benefits.
2. As a courtesy to you, we will file your insurance and accept assignment of benefits if you have signed the insurance payment authorization. We ask that your estimated copayment and deductible be paid at the time of service.
3. Not all services are a covered benefit in all contracts. Some companies arbitrarily select certain services they will not cover.
4. If a service is denied we will appeal it one time on your behalf. After we appeal if the claim is still not paid you will be responsible for the full amount

RELATED INFORMATION

1. For returned checks, a charge of $40.00 will be applied.

2. All balances may be subject to interest charges if not paid in a timely manner. These additional fees will be applied to the unpaid balance at the end of the month. Interest rates will be assessed at a rate of 1.5% per month or 18% annually.

3. In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court costs, and collection agency fees)

4. Your appointment time has been reserved exclusively for you. Any change in your appointment affects many patients. 48 hours notice is needed to avoid a $60.00 charge.

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.

I agree to be responsible for any charges not paid by my dental plan.

NAME(please print) _____

SIGNATURE_____DATE_____

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