# RAMOUNA KARVAR, D.M.D.

COSMETIC, IMPLANT AND FAMILY DENTISTRY

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## FINANCIAL POLICY AGREEMENT

Please feel free to ask questions regarding our financial policy at any time.

## NO INSURANCE

- Payment is required at the time of service.
- For your convenience, we accept cash, check, Visa, MasterCard and CareCredit.
- No interest or low interest payment financing options may be available through a third party, CareCredit. Please speak with our office manager if interested in applying.

## DENTAL INSURANCE

- **Your estimated portion is due at the time of service.** Dental insurance will usually pay only a portion of the total fee for most procedures and is a benefit employers offer their employees. As a courtesy to you, we will bill your insurance company for their portion of your treatment.
- Insurance is a contract between you, your employer, and the insurance company. Our office will do our best to explain our understanding of your coverage, but we are not able to know all the terms, limitations, and changes in your policy. We will not become involved in any disputes between you and your insurance company regarding payment for services. **You are a responsible for the timely payment of your account.**
- For your convenience, we accept Visa, MasterCard, checks, or cash.
- No interest or low interest payment financing options may be available through a third party, CareCredit. Please speak with our office manager if interested in applying.

## MISSED APPOINTMENTS

Please help us serve you and our other patients better by keeping scheduled appointments or letting us know if you need to change your appointment well in advance. Our policy is to charge for a missed appointment unless they are cancelled at least **48 hours** in advance. There is a $50 PER HOUR charge for missed appointments or last minute cancellations.

## MONTHLY STATEMENTS

We make every effort to provide you with an accurate amount due at your time of visit. However if there is a discrepancy in the amount we will sent a statement giving approximately 30 days for payment. Any accounts past due may be charged a $10 late charge. There is $25 charge for returned checks. Any fees incurred in the attempt to collect delinquent accounts will be the patient's responsibility.

## FINANCIAL CONSENT

I (patient/guardian) agree to be fully responsible for payment of treatment performed. I understand and agree to this Financial Policy and Agreement.

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Signature of Responsible Party Date