OFFICE POLICIES

Dear Patient (s),

Dr. Binh. Hoang and staff are committed to providing nothing short of excellent costumer and dental services. We prosper in knowing that we can make each one of our patients feel welcomed, leaving with a smile of satisfactory and, the knowledge that we truly care.

We strive to make everyone of our patient's experience as pleasant and timely as possible.

In order to do so, we ask that our patients be mindful of making sure that they are on time to their appointment. Please know that when you are late, you will be pushing back the next patient's appointment as well.

Please read the following and sign below. If you need clarification, on any item, please do not hesitate to let us know:

- Canceling or rescheduling appointments must be made at least 24 hours in advanced; we will reserve the right to charge each patient a $35.00 fee if the 24 hour notice is not given. Due to the high demand for Saturday appointments we ask a minimum of 48 hours cancellation/rescheduling notice. If patient is a no show or cancels with less than 48 hours notice, we will reserve the right to charge a $50.00 fee for each failed appointment.

- If you are more than 15 minutes late for your appointment, we reserve the right to cancel it and/or ask you to reschedule.

- **Payment is expected at time of service**. There will be no exceptions unless other arrangements have been agreed to **prior to you receiving any services**.

- If patient has an outstanding balance that is 90 days overdue and no payment arrangements have been made, the account will be turned over to a collection agency. We reserve the right to hold the patient liable for any and all legal fees in pursuing the funds that are due to the office.

- **Patients with Insurance**. Please note that our office will extend the courtesy and make reasonable accommodations to verify your insurance, submit claims on your behalf and help you find answers to questions you may have about your insurance policy. In spite, policies vary so much that it is impossible for our office to know every detail about each policy. It is ultimately the patient's responsibility to understand their own policy. We will make efforts to collect payment from your insurance. However, in the event that the patient's insurance does not pay or under pays our office for services rendered, the patient will be responsible for any unpaid amount.

I, ***(Signature)*** _____ ***Date*** _____ have read the policies of this office and **agree** to comply with their provisions.

** If patient does not agree to these terms, please initial and date below **

"I had the opportunity to review this document and choose not to acknowledge it." _____