RELEASE AND FINANCIAL RESPONSIBILITY AGREEMENT

Welcome to our office! We hope this information form will answer some of your questions about our office's financial & insurance policies.

Payment is expected at the time service is performed. We accept cash, personal checks with proper identification, Visa, Mastercard, Discover, American Express, Carecredit & debit cards.

Insurance Filing:

The patient is ultimately responsible for payment in full of their account, **NOT THE INSURANCE COMPANY.** *We do, however, file dental insurance claims as a courtesy to our patients. Most insurance companies have their own schedule of "allowable charges" for each procedure & may not be the same as the actual charges in our office. Based on our experience with your insurance company, we will calculate your copay as closely as possible.*

Extended Payments:

We do not have an "in house" payment plan for extended payments. However, we have applications for payment plans from CareCredit. This financing program must be in place prior to your treatment appointment.

Collections:

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for the payment of the regular fee for procedures at the time of service. If an account cannot be cleared within 60 days, it will be reported as "bad debt" with all three credit reporting agencies. We prefer not to use a collection service, but ***if circumstances make it necessary for us to pursue a collection account, all collection fees, attorney fees & interest at the rate of 1.5% per month may be added.***

Cancellation Fee:

To avoid a ***missed appointment fee of $50*** *(72 hours) notice is required prior to any cancellations other than extreme emergencies.*

I accept full financial responsibility for the services rendered to me by the staff at Peak Dental Care. I have read, understand and agree to the policies outlined above.
I hereby authorize Dr John Y Kim DDS to release my information acquired in the course of examination of treatment to my insurance carrier or other dental/medical professionals.

Patient/ Guardian Signature Date
(Required if a minor)

Staff Signature/ Witness Date