Casey Patterson, DDS
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Simi Valley, California 93065

Financial and Office Policies

Thank you for choosing us as your healthcare provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

Payment for Services

- Full payment is due at the time of service
- We accept cash, checks and all major credit cards
- We offer extended payment plan options through Care Credit with prior credit approval

Patients with Dental Insurance: We may accept assignment of insurance benefits; however, we do require your *estimated* portion be paid at the time of service. We make every effort possible to insure accurate estimates based on the insurance information on file, however, it is not a guarantee of benefit and all portions not paid by your insurance are your sole responsibility. We cannot bill your insurance company unless you give us accurate insurance information; any changes in that information are your responsibility to convey to us. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. We will make every effort to collect from your insurance company, however if your insurance does not pay the estimated insurance portion of your treatment, we will send you a statement for the balance and you will need to seek re-imbursement from them directly. Please be aware that some of the services provided may be non-covered services and not considered for payment by your insurance pursuant to your specific plan guidelines.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless consent forms have been previously signed by a parent/guardian, and charges have been pre-authorized to an approved credit plan, credit card or payment by cash or check at time of service has been verified and parent or guardian has signed consents for treatment in advance.

Cancelled or Missed Appointments: For each appointment, a specific amount of time and material is reserved especially for you. We strongly encourage all patients to keep their appointments. If you must change your appointment, we require **24 hour notice** to avoid a **$50** appointment fee.

By signing below I acknowledge I have read and fully understand the Financial Policy. I understand my insurance will be billed as a courtesy to me and any estimate given to me is simply an estimate based on the insurance information on file. I understand all portions not paid by my insurance are my financial responsibility. I acknowledge it is my responsibility to update my personal and insurance information.

Signature: ____ Date: ____________________

Printed Name: ____