# NEWPORT BEACH DENTAL ASSOCIATES
# FINANCIAL POLICY
# STATEMENT OF FINANCIAL RESPONSIBILITY

Thank you for using Newport Beach Dental Associates as your dental provider. We are commited to your treatment being successful. 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. All patients must read and sign this policy before being seen.

**ALL COPAY AND DEDUCTIBLE MONEY ARE DUE AT TIME OF SERVICE**
**WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD.**

## REGARDING INSURANCE

Your insurance is a contract between you and your insurance company. We are not a party to that contract. All charges incurred are the responsibility of the patient or their guarantor. We will bill your insurance company as a courtesy. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. If your insurance company has not paid your account within 60 days the balance will automatically be billed to you. Please be aware that some of the services provided may be a non-covered benefit. Benefit inquires and authorizations are not a guarantee of payment by your insurance company.

## USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for out 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 adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, Mastercard or payment by cash or check at the time service has been provided, along with a signed consent form.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____
Name Printed

_____ _____
Signature of Patient or Responsible Party Date