



Financial Policy and Treatment Estimate

At South Bay Periodontics we strongly believe that a good doctor/patient relationship depends upon communication and understanding. Our goal is to avoid any confusion concerning payment by providing you with our office Financial Policy and estimate of your treatment costs calculated and based on information provided to us by your benefits company prior to your treatment.

We accept most major benefit plans. We are considered in network with Delta Dental at the premier level and are considered out of network with all other carriers. As a courtesy to you we file claims directly to your carrier but all estimates provided to you prior to treatment are estimates only. Final payment is determined by your carrier when the claim is received. Your benefits are a contract between you and your carrier. At times you may need to contact your carrier personally to solve problems. We will notify you promptly if this is the case. All payment is contingent upon satisfied deductibles, available benefits, and patient eligibility. A predetermination of benefits will only be filed when requested by the patient.

While we always do our best to help you in filing your claims and receiving payment from your benefits company you (the patient) are ultimately responsible for the total cost of professional treatment rendered to you. We estimate your cost as close as possible. We cannot guarantee any payment from your carrier. You will receive a statement for any remaining balance after your benefits pay and will be due within 30 days. In the result of your benefits company paying more than we anticipate you have the option of either keeping a credit on your account for future treatment or receiving a refund. Please allow up to 30 days from receiving final payment from your benefits company to request a refund. It is also possible that treatment plans may change as treatment is rendered. Unexpected treatment may become necessary and a revised estimate will be provided. All estimates are honored for a period of 3 months.

Your estimated out of pocket is due within 5 business days of your surgery. Our office accepts payment by Cash, Check, Care Credit, Cherry Payments and all major Credit Cards.

Please initial _____

We require 5 business days' notice to cancel or change an appointment. This policy helps us manage our schedule and serve all our patients effectively. To avoid a late notice fee, please ensure any changes are made within this timeframe. Failure to provide the required notice will result in a late fee of \$75.00 per hour for hygiene appointments, or 10% of your total fee for surgery appointments.

Please initial _____

By signing below you are agreeing to the above terms.

Signature of patient or guardian

Date

Name of patient