Office Policies

Robert P. Choi, DDS
Family & Cosmetic Dentistry

Appointments

We make every effort to schedule appointments at your most convenient time. Please arrive at your scheduled appointment on time in order to minimize delay to other patients. To keep our practice fees from rising, due to unfilled appointments, please choose your time carefully and cancel only when absolutely necessary.

Cancellation Policy If you cannot keep a scheduled appointment, please call our office to cancel and reschedule as soon as possible. We ask that you give us at least a 24-hour notice. If you fail to keep your appointment, with less than 24 hours notice, you will be charged a fee of $75 for hygiene appointments and $50 per half hour for dental appointments. You have five (5) working days to dispute any cancellation fees by phoning our office directly regarding these disputes. Payment must be made in full prior to any further services rendered by our office.

Insurance

It is the patient's responsibility to provide our office with the correct insurance information as well as any benefit changes. Please be aware that your insurance coverage is a contract between you and your insurance company. You need to understand your policy and benefits; we are not a party to that contract.

As a courtesy, we submit dental insurance claims on behalf of our patients. All claims are subject to dental insurance review as follows: patient eligibility at time of services rendered; patient information submitted to provider; yearly maximum benefits; other pertinent terms of patient's insurance coverage.

If your insurance company does not pay within 90 days, you are responsible for the bill. Professional fees are your responsibility; whether or not your insurance provider pays. Also remember that the yearly deductible, co-payment(s), non-covered services, and any unpaid balances are also your responsibility. Please contact your insurance company for a total explanation of the benefits, terms, conditions, limitations and exclusions of coverage. A surcharge of $25.00 for additional handling will be applied to your account should your claim need to be submitted more than twice.

Billing & Payment

Statements are sent every 30 days for you to review and compare with your insurance statements. Only current information will be shown in detail. Please call our office if additional information is needed or if you feel an error has been made.

Payment Options We accept cash, checks, and the following credit cards: Visa, Mastercard, and ATM/Debit cards. We also offer 'Care Credit', an outside credit firm which allows interest-free payments for a specific time. Remember that co-payments and deductibles are due at time of service. Also, benefit eligibility verification does not guarantee payment.

Return Check Fee A $25.00 fee will be charged for returned checks. If a check is returned to your account, only cash or a credit card will be accepted for future services.

Delinquent Balances If your insurance does not pay a claim, the patient will be responsible for charges and will be billed. You will have 30 days to pay the claim or balance or an interest rate of 7%, per billing cycle, will be charged to your account. All delinquent balances will be forwarded to a collection agency and will be considered inactive. To reactivate your account, the unpaid balance and any collection fees must be paid in full to the collection agency.

Administration Fees There is a $75.00 administration fee for copies of dental records which will be due and payable upon completion of this service.

HIPAA Agreement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1) Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly. 2) Obtain payment from third-parties. 3)Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change Notice of Privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request, in writing, how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions; if you do agree, you are bound to abide by such restrictions.

Agreement

By signing below I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

_____

Patient Name

_____

Responsible Party

_____ _____

Relationship Date