Choon Sung Park D.M.D.

Office Policy/Insurance Agreement

APPOINTMENTS: We recognize the value of your time. Therefore, we will do our best to see you as promptly as possible. It is important that you come to your appointment on time so that we can treat you and our other patients in a timely manner. Patients must arrive no later than 10 minutes from their appointment time to ensure their appointment for that day. Also, if you have a time urgency and must be completed by given time, please inform us upon your arrival and we will do our best to accommodate you.

CANCELLATIONS OR BROKEN APPOINTMENTS: We are able to extend a "no charge" fee to our patients who give our office 24-hour notice of a need to change their appointment time. Patients who do not give our office this courtesy will be assessed a $85.00 charge for each appointment missed. Large blocks of time are discouraged if you are unable to commit to the time, such as families coming in together, longer treatments or multiple appointments, and require a minimum of 72 hour notice for cancelling.

FINANCIAL ARRANGEMENTS: We strive to keep ours fees as a reasonable as possible to our patients. Payment is to be received the day the services are rendered. We ask all new patients joining our practice to pay the initial charges, regardless of insurance involvement. Accounts that are 90 days overdue are subject to a 1.5% service charge. Payments may also be made through **VISA, MASTERCARD, AND DISCOVER, And CareCredit Financing.**

Signature of responsible party_____Date:_____.

Office Exams and X-ray Policy

Exams: We value our patient's oral health, and therefore we will do standard periodic exams at six month intervals. Additional exams throughout the year are not done in lieau of periodic exams. X-rays are required in our office so that we may diagnose all conditions including but not limited to caries, bone loss, periodontal disease, calculus, and infections. The standard of care is bitewing and periapical x-rays on a yearly basis. Full mouth x-ray series are done for a new patient comprehensive exam and repeated every 2-3 years. I understand and agree to these policies regardless of insurance limitations.

Signature of responsible party_____Date:_____.

Financial Arrangements (Patients with Insurance): Please read and sign this statement before we agree to accept payment assignment directly from your insurance company. This avoids any misunderstandings and facilitates processing of your insurance claim. If you have questions, please ask us. Thank you.

* I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment within 90 days, I will be responsible for the full amount owed to Dr. Park.
* I understand and agree that I am responsible for the estimated amount not paid by the insurance company. * I understand that, after the insurance company pays Dr. Park, there could still be a balance remaining, for which I am responsible.
* I understand and agree that, before treatment begins, if the estimate of insurance benefits indicates a large amount due by me, and I feel I cannot pay it during treatment, I can request a written financial agreement (terms to be discussed at that time.)
* I understand and agree that, from the time of treatment is rendered: I will have 90 days to clear my balance. If my account is 90 days overdue, I will be subject to a 1.5% service charge. I can make payments through **VISA, MASTERCARD, AND DISCOVER, or I can apply for a CareCredit Payment Plan.**

Signature of responsible party_____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF

Dental Materials Fact Sheet (California Law)

&

Notice of Privacy Practices (Federal Law)

Please note: This office is legally required to provide you with this information, and we are legally required to ask you for a signature acknowledgement of receipt of both documents. Based on the latest research and clinical experience, we have always tried to help you select the best dental restorative materials. Likewise, the confidentiality of patients' health information has been priority from the day this practice began. However, our infinitely wise lawmakers decided that you need more details about dental materials and more reassurance about our privacy policies. So, enjoy the information and ask related questions or ignore it and throw it away. <u>You may refuse to sign this acknowledgement .</u>

I ,_____, have received copies of both The Dental Materials Fact Sheet (dated October, 2001) and this office's Notice of Privacy Practices (revised in 2013).

Please Print Name_____

Signature & Date_____

I,_____, authorize information about my treatment, and any other pertinent issues such as the account to:

Spouse:_____.

Family Members:_____.

Other:_____.

None (excluding necessary information to insurance and other medical providers_____
_____

By recent law, insurance companies are required to offer translation services, if requested, by the patient or family member of the patient. Do you require these services. Yes No What Language_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of the Dental Materials Fact Sheet and our Notice of Privacy Practices, but acknowledgements could not be obtained because:

( ) Individual refused to sign

) Communication barriers prohibited the acknowledgement

) An emergency situation prevented us from obtaining acknowledge

( ) Other (Please Specify_____