Dr. Kim's Smiles Dentistry

Patient Statement of Financial Responsibility

Thank you for choosing Dr. Byoung J. Kim, DDS for your Dental needs. Our staff is committed to enhancing the quality of your smile and overall healthy teeth. This policy and release statement has been designed to inform you of our policies and answer your questions regarding payment of services. Please be sure that you have read and understand all the information provided in this statement before signing the release. As our patient your signature is both binding and acknowledges your understanding and compliance with our policies.

Payment for Visits

For the convenience of our patients we accept Cash, Visa, Master Card. Co-payments and deductibles required by individual insurance plans are due at the time the services are rendered. Sorry for any inconvenience but we do not accept any form of check.

Payment for Treatment

Co-payments or deductibles toward treatment are the patient's responsibility and must be paid the day service is rendered. If payment is not received treatment will be postponed. We will give your insurance company 45 days to pay claims. If they do not pay within time allowed the balance can and will be transferred to your account.

Self-Pay Patients

We welcome self-paying patients when insurance coverage is not available for our services. Patients without insurance are asked to assume full financial responsibility for the office visits, lab fees, and any services rendered during the time of service. If for some reason full payment cannot be made at the time of service please speak with an administrator prior to your office visit to determine if reasonable payment arrangement can be established.

Cancellations and Missed Appointments

In order to be respectful of the dental needs of others please be courteous and call our office at least **24-hours** in advance if you are unable to attend or must reschedule an appointment. If failed to comply you will be charged $25 for each hour that we had reserved for you dental treatment.

RELEASE

I hereby acknowledge that I have read, understand and agree to comply with all policies outlined herein. I also acknowledge should my account go to collections, I will be charged the collections service fee in addition to all outstanding balances.

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Signature of Patient/Responsible Party Date

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Print First and Last Name