CUSTOM DENTAL
GENERAL & COSMETIC FAMILY DENTISTRY
3409 CALLOWAY DRIVE UNIT 402
BAKERSFIELD, CA 93312
661-387-6577

Financial Policy v1-4

Thank you for choosing Custom Dental as your dental provider. Our office is committed to providing you with the best possible care. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Patient Record, Informed Consent, Health History, and Financial Policy forms before seeing the doctor.

Regarding Payment

We accept the following forms of payment: Cash, Check, Money Order/Bank Check, Visa, MasterCard, Discover, American Express, Flexible Spending Accounts and CareCredit.
Checks that are returned to our office from your financial institution are subject to a $25.00 returned check fee. This fee covers the processing fees that are charged to our office.

Payment in full is due at the time services are rendered.

For major work (dentures, partial dentures, crown and bridge, implant related, Invisalign, etc) a 50% deposit will be required to start the procedure and the remaining balance will be due at the delivery date.

In order to get quality care and avoid jeopardizing your treatment, it is important for you to keep your scheduled appointments. **As a reminder, since we normally do not double book, each of your appointments are exclusively reserved just for you!** Because of this, there will be a fee of $25 charged for any missed appointment that is cancelled or rescheduled with less than 24 hour notice. Due to overtime hours for the office staff on weekends, missed appointments with less than 24 hour notice on Saturdays will be assessed a mandatory fee of $25 that is not subject to frequency of occurrence. This mandatory charge also applies to any missed appointments scheduled for over one hour.

Regarding Insurance

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Pre-authorization from your insurance is required before any major work is started in order to protect you from unexpected payment responsibilities. We make every effort to provide for you an accurate estimate with the information you and your insurance provide us. Please be aware that your patient responsibility estimates are only an approximation and may change as we acquire more information from your insurance. Insurance co-pays and deductibles must be paid at the time of service**. If for any reason your insurance does not pay its expected portion for a completed procedure, that balance will become the responsibility of the patient and a statement of balance due will be generated and sent to you.** Please be aware that the process of insurance billing and auditing of patient accounts may occur sometime after your date of service. We always strive to ensure all insurance payment information and patient responsibilities are correct and proper.

All invoices are due and payable within 30 days of service. Interest will be charged on past due invoices at the rate of 1.5% per month (18% per annum). In the event it becomes necessary to turn your account(s) over to a collection agency or use an attorney, I (we) promise to pay, in addition to the amount due, all costs of collection, court costs and reasonable attorney fees. The parties agree that the jurisdiction for any dispute under this contract shall be the County of Kern.

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

By signing below, I acknowledge that I have read and understand the Financial Policy v1-4 as outlined in this document. I consent use of my cell phone for communication in regards to my account and insurance.

Signature of Patient or Responsible Party: _____ Date: _____

Print Patient Name:_____