DR. ANTHONY LY'S PATIENT POLICIES

The office of Dr. Anthony Ly has the following patient policies. **All patient policies are subject to change at any time. Dr. Anthony Ly's dental office has reserve the right to refuse any patient at anytime.**

Insurance:

Verifying insurance coverage and filing claims for benefits are services we provide to our patients at no cost. We do as much as we can, however it is ultimately the patient's responsibility to contact the insurance company to find out what procedures will and will not be covered by their insurance plan. We DO NOT ACCEPT RESPONSIBILITY FOR INSURANCE DELAY. The same applies to the payment of benefits by the patient's insurance plan.

If we do not have time to verify insurance of the patient prior to his/her appointment time, the patient is responsible for charges due that day up until the point that the patient's insurance can be verified.

Many insurance plans are available to patients; however our office does not accept every type of insurance available. If you have an insurance plan that we do not accept, our office will provide you with a 15% discount since we do not want to penalize the patient for having insurance eligibility and benefits (see last page for more details).

____ **Yes, I understand in order for Dr. Ly to provide proper dental care, that some necessary procedures will not be covered by my insurance. Therefore, I give Dr. Ly the authority to perform any procedure necessary to achieve/maintain my oral health.**

____ **No, I elect to only allow Dr. Ly to perform dental procedures that are clearly stated to be covered by insurance.**

Financing:

Our office offers two types of financing agreements to our patients. We offer in-house financing on a case–by-case basis as well as external finance plans. Care Credit and Citihealth Plan is two external finance companies that we use. This financing company offer 0% interest plans up to 12 months.

For patients who do not have dental insurance, we offer you a 5% discount; however, you will not receive the 5% discount if you choose to use an external financing company since we are charged for these services.

Courtesies and Perks:

This office offers many courtesies to our patients. We give courtesy appointment reminders via email and text message. Please provide our office with the correct information so that we can contact you through our reminder systems. ***The patient is ultimately responsible for remembering his/her appointment date and time.***

Cancellations and Rescheduled Appointments:

We understand that schedules change and emergencies come up. However, due to the increase of patient volume in our office, we request a 24 hour notice for CANCELATION AND RESCHEDULED APPOINTMENTS. A $50 fee will be charged to your account after the second cancelled or rescheduled appointment less than 24 hours. A $75 fee will be charged to your account for NO SHOW APPOINTMENTS. Patients incurring these fees will not be seen for future appointments until balance is paid in full. Emergency after hour visits are $300, not including any treatment performed. We truly appreciate your understanding.

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Office Payment Policy:

Payment is expected at the time services are rendered. We except Cash, Checks, Visa, MasterCard and Discover. Any accounts sent to a collection agency will be charged $100.00.
NSF fees: If a check is returned, the patient's account will be charged $50.00 plus any charge incurred from our bank. Also, once you have issued a NSF check to our office, we will no longer accept checks as a form of payment from you. All fees are subject to change at any time. All "treatment plans" prices and discounts are null and void 30 days after it was presented unless the patient has begun treatment or has requested an extension in writing.

Patient Records:

We will not release your records without your written consent. **This includes any personal information, images, your dental records, and any other information accumulated at our office. You must sign a release form in person or fax permission before we can release your records. If the patient needs a copy of his or her x-rays, we reserve the right to charge a duplication x-ray fee: $25.00 Bitewing and Pano x-rays. We require a 24-hour notice and a written request for x-ray duplicating.**

Please check whether you agree with and understand all of the above patient policies. If you do not agree with some of the policies, please tell us so that we may discuss them. If you do not agree with the patient policies, we request that you seek dental treatment elsewhere.

_____ I agree with all of the above patient policies. I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN TO ME VERBALLY. BY MY SIGNATURE BELOW I CONSENT TO ABIDE BY THE ABOVE POLICIES.

Patient Signature_____ Date_____