



Richard Leong, D.D.S. | 115 W. Stewart Ave., Suite 101 | Medford OR 97501

**Financial Policies**

Taking care of you and your family is our highest priority. Our goal is to provide you with clear information regarding our dental fees and your payment options. Prior to the onset of treatment, we will provide you with an *estimate* of the fees expected. Treatment needs can change for a variety of unforeseen reasons. Whenever possible, we will inform you of any treatment changes that will affect your financial estimate.

**INSURED PATIENTS**

Insurance coverage, reimbursement and benefits are a contract between you and your insurance carrier. Rogue Dental provides insurance billing as a courtesy to our patients. The patient portion of services rendered will be estimated and due at the time of service. It is your responsibility to provide our office with accurate insurance information. If accurate information is not provided, self-payment guidelines will apply. If you are unable to pay your portion in full at the time of service, you will need to meet with the office coordinator prior to scheduling to discuss payment options.

The claims we submit to insurance companies indicate that you have assigned those benefits to Rogue Dental. However, if you are paid by the insurance company instead of Rogue Dental, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family member has more than one dental insurance policy, we will assist you in obtaining the maximum benefits available. Please be aware that coordination of benefits varies and there may be instances where the two insurance companies will not pay 100%. In such cases you will be responsible for any amount now paid by insurance.

**UNINSURED PATIENTS**

Payment is due in full at the time of service unless payment arrangements are established prior to your appointment. A 5% discount will be offered for cash or check payments made at the time of service.

**PAST DUE ACCOUNTS**

Accounts become delinquent 90 days following the date of service and these charges may be assigned to a collection agency. A pre-collection letter will be mailed.

**LATE CHARGES**

If a payment plan is arranged and your minimum payment is not received by the due date, you will be assessed a late payment charge of \$5.00 or 5% of the past due minimum payment, whichever is greater. The late charge will not exceed a maximum of \$20.00.

**FINANCE CHARGES**

A finance charge is imposed on those charges not paid in full within 60 days of the date you were first billed for charges. The finance charge rate is 1.50% per month (an annual percentage rate of 18%). There is a \$.50 minimum charge.

**MISSED APPOINTMENT FEE**

If you miss your appointment, or cancel with less than 24 hours-notice, there will be a \$50 missed appointment fee charged. Please help us to help others by calling 24 hours prior to your appointment to cancel or reschedule.

**RETURNED CHECKS**

There is a fee of \$25.00 for any checks returned by the bank.

**I HAVE READ AND UNDERSTAND THIS FINANCIAL AGREEMENT. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND HAVE RECEIVED A COPY. I ACCEPT THE RESPONSIBILITY OF ITS TERMS.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If someone other than the patient is signing, please state the relationship to patient. \_\_\_\_\_