MELBA Z. MAYES, D.D.S., M.S.
PEDIATRIC DENTISTRY
2140 GRAND AVENUE, SUITE 200 • CHINO HILLS, CALIFORNIA 91709
(909) 548-4044 • (909) 548-0848 FACSIMILE

OUR FINANCIAL POLICY

Thank you for choosing us as your child's dental care provider. Our staff welcomes you to our office and would like you to know that we are committed to providing your child with excellent dental care. In order to achieve these goals, we need your assistance and understanding of our payment policy. Please understand that payment of your bill is considered a part of your child's treatment. As part of our service and in effort to contain the ever-rising cost of health care, we have a financial policy.

The following is a statement of our financial policy. Please read it carefully and sign prior to any treatment. You may have a copy for your records. If you have any questions regarding the provisions of this financial policy, please ask. We will be happy to discuss it with you.

A treatment plan will be prepared for you which will detail your child's dental needs as well as the related estimated costs of that treatment. Our office is a fee for service dental office, and full payment or insurance co-payments are due at the time of service.

We are sensitive to the fact that some patients may require alternative payment options, and therefore we accept cash, checks, or credit/debit cards (Visa or MasterCard only).

Regarding Dental Insurance
There are many types of dental insurance. Some of them are considered great to work with and allow the dentist and parents to decide which treatment options are best for your child. Others are very difficult to deal with, thus preventing the dentist from providing the highest quality dental care for your child. This office is not willing to allow insurance companies to influence our standard of care, so there are insurances that we are willing to bill for our patients and there are others we will not.

If you have dental insurance, we cannot bill your insurance company unless you give us your insurance information and an original claim form. Your insurance policy is a contract between you, your employer, and your insurance company. We are not a party to that contract. If you are deemed ineligible for your insurance benefits at the time of service, you are responsible for payment of services.

If you have dental insurance, we ask that you pay any deductibles and co-pays at the first appointment. If necessary, please utilize one of the payment options listed above.

Please be aware that we are able only to estimate what your insurance coverage may be, and that the actual patient portion may be more than we expect. Depending on your enrollment status, all of the services provided may be non-covered services. The balance is your responsibility whether your insurance company pays or not. All balances, which remain over 45 days, are subject to a 1.5% monthly finance charge.

If a check payable to our office is returned to us due to insufficient funds or for any reason, you are responsible for all bank charges incurred by us as well as the total remaining balance on the account within seven (7) days. Failure to pay our office may result in adverse actions taken against you, such as collections, legal actions, or the reporting of negative information to credit reporting agencies. A charge of $35 will be applied to all delinquent accounts being sent to collections.

Appointments
Appointment times are reserved especially for your child. If you must change your appointment time, we ask that you notify us at least 48 hours in advance. If a pattern of late cancellations or no-shows develops, you may be subject to a $75 set-up charge, for each missed appointment.

Usual and Customary Rates (UCR)
Our practice is committed to providing exceptional treatment for our patients and we charge what is usual and customary for a specialist in our area. You are responsible for full payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns. I have read and understand the office policy stated above and agree to accept responsibility as described.

Date:_____ _____
Signature of Parent, Guardian or Personal Representative