Financial Policy

Insurance:

As a courtesy to our patients, we will happily file any necessary forms to insure you receive the full benefits of your dental coverage. We advise you read your policy to be fully aware of your coverage and any limitations on the benefits provided. If your insurance denies coverage the balance will then become due and payable to you. Your dental benefits are a contract between you and your insurance and/or your employer and your insurance. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance to pay.

Estimates:

Eastside Dental has a software system which allows us to estimate your insurance benefits once Dr. Singh has identified and explained any necessary treatment. Your estimated portion will be due at time of service. The treatment coordinator will explain your estimated portion. Regardless of any estimated insurance coverage, any fees incurred for services received will be your financial responsibility.

Uninsured Patients:

Payments for any dental services received are due in full at time of service.

Payment Options:

Payments can be made with check, cash, or credit card. For your convenience we have made arrangements to accept most major credit cards.

Appointments/Cancellations:

We gladly reserve an appointment time for you with Dr. Singh, and as a courtesy will attempt to remind you of your appointment by confirming your scheduled date and time. If we cannot speak directly to you we will leave a message. We do require a 24 hour notice if you need to change an appointment. We reserve the right to charge $50 per hour for appointments canceled or broken without 24 hour notice.

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- I acknowledge and understand my responsibility for payment of all dental services provided by Dr. Singh in accordance with their fees and terms.
- I understand my responsibility is not waived based on whether or not any third party, such as insurance; pays for all, part, or none of the charges.
- I understand that my account becomes delinquent if not paid within 90 days after billing, at which time any unpaid balance is subject to reassignment to a collection agency.

Assignment and Release:

I authorize payment to be made directly to Dr. Singh by my insurance for any treatment rendered to myself or my dependents. I authorized Dr. Singh to furnish my information to insurance carriers concerning any dental treatment I or my dependent(s) receive.

Patient Signature:_____

Printed _____Date: _____

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