DOUGLAS B. WEBER, D.D.S. INC

General and Cosmetic Dentistry
44404 16th St. W. Suite 201
Lancaster, Ca. 93534

Office Financial Policy

Thank you for choosing us as your health care provider. We are committed to your successful Treatment, and payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy that we require you read and sign before any treatment.

You must complete our PATIENT HISTORY AND INFORMATION FORM and sign this form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE

WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, DISCOVER, AND AMERICAN EXPRESS

WE OFFER EXTENDED PAYMENT PLANS WITH PRIOR CREDIT APPROVAL (CARECREDIT or Capital One Healthcare Finance)

Missed Appointments

Unless canceled, at least 48 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit($35.00), per every 1/4 hour of missed appointment time.

Regarding Insurance

We may accept assignment of insurance benefits on your first visit, however we do require your estimated patient share be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information, and an original claim form if necessary. Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. **If your insurance company has not paid your account in full within 120 days**, we will ask that you pay their share, and we will allow you to collect the check. We may make exceptions to this policy on a needed basis. ***Please be aware that some, and perhaps all, of the services provide may be non-covered services and not considered reasonable and necessary under your dental insurance plans.***

Regarding Insurance Plans where we are a participating provider: **All co-pays and deductibles are due before treatment**. In the event that your insurance coverage changes to a plan in which we are not participating providers, refer to the above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.
You are responsible for payment despite any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor, or the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MASTERCARD, or payment by cash or check at time of service has been verified.

Thank you for understanding our ***Office Financial Policy***. Please let us know if you have any questions or concerns. By signing below, you are certifying that you Understand and Agree with the above financial policy.

_____ date _____
Signature of Patient if not Responsible Party

_____ date _____
Signature of Responsible Party for account