Dr. Shuan Chavez
(503) 640-4674

OFFICE FINANCIAL POLICIES

BE ADVISED WE STRICTYLY ENFORCE THESE POLICIES.

1.) **DENTAL SERVICES**: Copayments are due at the time of the appointment.

- **Forms of Payment**: Cash, Checks, Mastercard, Visa, American American Express and Care Credit. A $25 fee will be added to any balance that has a returned check.

2.) **INSURANCE BILLING/PAYMENTS**: Our office will bill your dental insurance company as a courtesy. We request that you provide us with the necessary information in order to bill your insurance correctly. We do require you to pay any deductibles, copayments and percentages of treatment (if applicable) the day services are provided. We do not send out monthly statements. Statements are only created for outstanding balances. After billing your insurance, you may still have a balance after the insurance pays that you will be responsible for. Copayments at the time of the appointment are only estimated because we can not be exact on what your insurance will pay sometimes. Any account over 60 days past due will incur an annual fee of 18% on any remaining balance.

3.) **MISSED APPOINTMENTS**: We charge a $50.00 fee for a missed appointment. We ask that you provide 24 hours notice if you need to cancel an appointment for any reason.

4.) **LATE APPOINTMENTS**: Patients arriving more than 15 minutes late into their scheduled appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment, and the $50.00 missed appointment charge will apply.

5.) **FINANCIAL ARRANGEMENTS**: I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of my account owed on this or a subsequent visit, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. For any reason the account should be turned over to a collection agency, 10% of the principle balance will be added for Interest and 10% for Service charges in addition to any late fees incurred for late payments made to Dr. Shuan Chavez, D.M.D., P.C.

By signing below, I have read and agree to all the statements listed above.

_____ _____

Responsible Party's Signature **Date**