FINANCIAL POLICY AND CONSENT FOR SERVICES

Thank you for choosing Randolph Kim, DDS, Family & Cosmetic Dentistry, for your dental care. Our team is committed to your overall health and the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.

Just as we are committed to providing you with the very best dentistry has to offer, so are we committed to making dentistry financially comfortable for you. As a condition of treatment, written financial arrangements are made in advance to ensure you understand your financial obligation. For your convenience, we accept cash, credit cards, debit cards and flex spending cards. We also have flexible payment options available.

INSURANCE: For those patients with dental insurance, we're happy to submit your dental claims on your behalf and your insurance will reimburse you directly.

TREATMENT PLANS: A treatment plan estimate is a good faith attempt to predict the cost of treatment. As treatment progresses, your dentist may determine in consultation that different or additional treatment is necessary and your financial responsibility may change. Treatment estimates can only be extended for a period of six (6) months from the date treatment was recommended.

AUTHORIZATIONS

❑ **By checking this box:**

- I authorize Randolph Kim, DDS, Family & Cosmetic Dentistry, to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance.
- I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Randolph Kim, DDS, Family & Cosmetic Dentistry.
- I grant permission to Randolph Kim, DDS, Family & Cosmetic Dentistry, to: *(check all that apply)*
  ❑**telephone** ❑**email** ❑**text** me to discuss my account or treatment.
- I understand that cancellations must be at least 24-hours in advance of a scheduled appointment. The charge for single missed appointments or appointments not cancelled within 24-hours will be charged at a rate of $50 for each hour scheduled.
- I understand that interest of 5.25% per month will be added on unpaid balances over sixty (60) days; accounts over ninety (90) days delinquent will be sent to a collection agency and a collection fee of 35% of the balance will be charged to my account; a $50 charge will be added to my account for a returned check.
- I understand that it's my responsibility to notify my dentist within thirty (30) days of service if there is a problem. I also understand the through this notification, my dentist will act on my behalf to attempt to correct the problem or provide a referral to another health care practitioner. Any concerns past thirty (30) days will be the responsibility of the patient and any services provided will be an additional cost to the patient.
- I accept and agree that there are risk and limitations to all procedures. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee and/or assurance has been made by anyone regarding dental treatment that I have requested and authorized.

I CERTIFY THAT I HAVE READ AND I UNDERSTAND THE ABOVE INFORMATION. I acknowledge that all my questions have been answered to my satisfaction. You have the right to accept or deny treatment before it is performed. The fee(s) for these services have been explained to me and I accept them as satisfactory. I understand that I am responsible for payment in full at the time of service unless other financial arrangements have been made in writing. By signing this form, I am freely giving my consent to authorize Randolph Kim, DDS, Family & Cosmetic Dentistry, including the dentists, hygienists, and administration to use and/or prescribe anesthetic agents and/or medications. The Randolph Kim, DDS, Family & Cosmetic Dentistry, reserves the right to change or cancel these terms and conditions at any time.

_____	_____	_____
Patient Printed Name	Signature of Patient (Parent or Guardian)	Date

_____	_____
Witness Signature	Date