Orange County Pediatric Dentistry
Dr. Dayna Olstein
Dr. Arielle Rolon

Financial Policy

PATIENT INFORMATION					
First Name		Last Name		DOB	

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

Patients must fill out information forms prior to seeing the doctor. We will request a photocopy of your insurance card(s) for our file.

NON CO-PAY PLANS – If your plan does not require co-pay and we participate, we will accept the designated fee. You are responsible for any deductible and balance your plan does not cover. Any returned checks are subject to a service charge of $20.00 and any additional processing fees.

NON PLAN PATIENTS – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. We will be happy to mail your insurance forms for you.

BROKEN APPOINTMENTS – reserved appointment time in any office is limited and valuable. Our office requires a **24**-hour notice if a patient is unable to keep the scheduled appointment. A $50.00 charge will be incurred without notification.

ACCOUNT PAYMENT – You are responsible for timely payment of your account. Payment is expected within **30** days of the due date. There is a 1 % accrued finance charge for any unpaid balance for each month. In addition, once we have added a late fee of $5 to your billing statement, we may continue to do so each month for as long as your account remains unpaid. The patient is responsible for all collection charges and legal fees incurred in the collection of his or her accounts.

METHOD OF PAYMENT - Payment will be accepted in cash, checks, MasterCard, Visa, Discover and American Express.

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us any special concerns.

FORM COMPLETION			
Signature of Patient, Parent or Guardian:		Date:	
IF PATIENT IS A MINOR			
Form signed by:		Relationship to Patient:	