SOUTH COAST METRO

CENTER FOR DENTISTRY & IMPLANTS

WRITTEN FINANCIAL POLICY

Thank you for selecting South Coast Metro Center for Dentistry & Implants as your dental care provider. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

For patients without dental insurance, full payment is required at time of treatment unless we have authorized a different payment plan. For patients with dental insurance we will work with our carrier to maximize your benefits and directly bill them for reimbursement for your treatment. Not all services are covered benefits by your insurances.

Your insurance policy is a contract between you and the insurance company. Our financial relationship is with you and not the insurance company. **All charges are your responsibility whether your insurance company pays or not.** All of the information we provide regarding your insurance benefits are only estimates.

Fees for services, including deductibles, co-payments, and services and procedures not covered or denied under your insurance plan are due at the time of treatment. If the insurance company does not pay your covered benefits within 30 days, we will ask that you contact the insurance carrier to expedite the payment process.

If the insurance company does not pay your balance within 45 days, we will require that you pay the balance due. Balances older than 90 days are considered to be in delinquency and will be reported to the credit bureau and sent to collections. All fees associated with collection on your account will be your responsibility, including but not limited to collection agency fees in addition to the balance owed. A monthly 1.5% interest fee will be charged on account balances over 90 days.

Our office offers the following payment options:

- Cash, Check, Visa, Mastercard, American Express
- Payment Plans from CareCredit and Lending Club

Please note: We request 24 hour prior notice of any cancellations otherwise a $50 cancellation fee may be charged. Our office charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Signature_____

Name_____

Date_____