Nazanin Barkhodari, DDS
Financial Policy

We welcome you to our family of dental care providers and we are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment.
Payment is expected as services are rendered. If you are covered by insurance, we expect payment for deductibles and co-payments on the date of service. We accept cash, checks, Visa, MasterCard, American Express, Discover or we offer the CareCredit payment plan which allows low monthly payments with prior credit approval.

Regarding Insurance

We are happy to extend the courtesy of billing your insurance company for you. However, in order to provide this service to you, we must have complete insurance information and confirmation of your coverage. It is your responsibility to fill out the necessary forms that give us all the insurance information required. If this information is not provided to us in a timely manner, we will be unable to bill your insurance company for you and you will be expected to pay in full for services rendered. If we have not received payment from your insurance company within 45 days of billing, the balance becomes your responsibility. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. You will be expected to contact them directly if a problem should arise. We expect all balances to be cleared in less than 45 days.

Usual and Customary Rates

Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please keep in mind that we can only estimate what your insurance will pay since each insurance company has their specific limitations and exclusions.

Office Policy

There will be a charge for cancelling an appointment without 48 hours notice or for failing to show for an appointment.
The cancellation fee is based on procedure and procedure time.

I understand and agree to this office policy. Initial _____

Signature

Signature of Parent/ Guardian if Patient is a Minor: Date:

Doctor Signature: Date:

RESET SUBMIT