DENTAL OFFICE OF TATYANA YASHCHUK, DDS
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FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Golden State Dentistry to provide your dental care. Our philosophy is to be informative, honest and forthright with our patients in order to provide the highest quality of care possible. Nowhere is that more important than in the area of finances. This Financial Responsibility Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our financial policies, please do not hesitate to ask us.

TREATMENT FEE

Your treatment fee includes all required processes and office visits to complete the scheduled dental procedure. This does not cover any work done at any other office or laboratory outside our practice. We provide written estimates for required procedures beforehand. These estimates reflect our best estimate based upon the information known at the time the estimate is rendered. There are times when, during a procedure, the dentist realizes that additional or different work is needed. If that occurs, we will advise you of those facts. The estimated payment is due at the first visit for the agreed upon procedure, even if completion of the procedure requires multiple office visits. You can ask for the procedure price list from the Receptionist.

FORMS OF PAYMENT

We accept cash, money orders, cashier's checks, debit and credit cards. We do not accept personal checks. Financing options are available through CareCredit and must be secured in advance of treatment. You can also apply for CareCredit online at **www.carecredit.com**. CareCredit is not affiliated with our practice. It is a third party provider. Should you have any disputes with CareCredit, such disputes should be resolved directly with CareCredit.

DENTAL INSURANCE

The dentists and staff of Golden State Dentistry are not representatives of any given insurance carrier. As a courtesy, we gladly assist in filing a claim with your insurance company. However, the responsibility to pay for services provided always rests with the patient or patient's legal guardian.

If you are a patient with insurance that is considered **OUT-OF-NETWORK** in our office, you must provide a **FULL** payment for the entire procedure at the time of your first appointment for any given treatment, even if it requires multiple appointments. We will provide all necessary documentation for you to submit to your insurance company and will try to assist you in filing the claim with them. The insurance company will reimburse you directly for the covered portion of your procedures.

If you are a patient with insurance that is considered **IN-NETWORK** in our office, we will file the insurance claim for you, but you must agree to the following:

- Your insurance policy is a contract between you, your employer, and the insurance company. We are **NOT** a party to that contract.
- You must provide us with a valid identity document (ID), insurance card, and all the information necessary to verify your coverage and file your claim.
- If you have multiple insurance companies, we do not bill more than two insurance companies. Your portion (copay and deductible) will be determined by both insurance companies and we cannot predict what will be covered by which insurance company. Any remaining balance not covered is still owed by you.

- Although we may estimate your insurance benefits, we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely your responsibility. Not all the services we provide are covered benefits. Benefits vary based on your insurance company and insurance plan.
- Fees, along with deductibles and co-payments, are due at the time of service regardless of whether the procedure requires multiple appointments.
- After your dental insurance has paid its portion, a statement is sent to your mailing address on record and/or email, for any remaining balance. Payment is due within **30 days** of the statement date.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. If your insurance company does not pay after **60 days**, we will bill you directly for the full balance via billing statement. Interest will begin to accrue on any unpaid balance **30 days** after the mailing date of the statement.
- Receiving our services indicates your acceptance of responsibility to pay for our services, regardless of our estimate and/or what portion of the costs your insurance company covers.

Overdue Balance

If payment is not received within **30 days** of the mailing date of the statement, we will attempt to send another statement. After **60 days** from the date of the first notice, your account will be turned over to a collections agency and you will have to make payments directly to them. We will no longer be able to accept payments on balances sent to a collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt, which may include attorney fees, court fees, and any other fees associated with the collection of your debt. Moreover, at this time we may send you a notice that we will no longer be accepting you as our patient due to the delinquency in payment.

Interest charges will be applied to all balances not paid within **30 days** of the billing date at a rate of 10% per year.

Late or Missed Appointments

Our appointments are carefully scheduled around the providers' limited time and availability. Therefore, arriving more than 15 minutes late or missing your appointment will interfere with the pre-set schedule and potentially impact other patients. In fairness to the other scheduled patients who show up on time for their appointments, we may not always be able to fit in a late arrival into the schedule. We may have to re-schedule the appointment unless there is an opening in the schedule that we had not expected.

We notify patients of their appointment 2 weeks prior, as well as 2 days prior, by email, and 1-day prior by their preferred method, such as text, e-mail, or phone call. Keeping track of appointments is your responsibility regardless of whether a reminder is received or not. It is your responsibility to keep your contact information current with our office.

A **48-hour** advance notice is required if you need to change or cancel a scheduled appointment. Regardless of the reason, missed appointments without at least a 48-hour notice (including no-show appointments), or arriving more than 15 minutes late without notice, will be subject to a **$100** fee for each hour missed of the originally scheduled appointment, which will automatically be charged to your account or card on file. For appointments greater than 2 hours, we may require a deposit of **$100 per hour**, which will be applied to your treatment balance. In cases of a no-show to an appointment requiring a deposit, you will not be reimbursed the deposit amount. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

To cancel or change an appointment, please call Golden State Dentistry at **(925) 705-7093.**

MINOR PATIENTS

The parent or guardian accompanying the minor is responsible for the full payment for services rendered to the minor. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment and represents and warrants to us that s/he has authority to make decisions on behalf of the child, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit, unless **PRIOR** arrangements for payment are made via cash, money order, or credit card authorization.

PATIENT RECORDS

Original records including radiographs are the property of the office. Upon request, we will provide you with an electronic copy of your records or radiographs to your electronic device (flash card, CD, DVD, or hard drive). Please make any such requests to us in writing via email (info@goldenstatedentistry.com) and allow 2 weeks to produce such records.

If you would like us to release your medical information to a third party, please note that HIPAA requires such written authorizations to be written in plain, easily understandable language, and must:

(a) Identify the patient whose information is being requested;
(b) Identify specifically the individual(s) to whom the information is being furnished;
(c) Specify the particular records or information which will be disclosed;
(d) Specify the purpose for which the information being disclosed will be used;
(e) Specify the length of time for which the party receiving the information will have access to it;
(f) Specify how the patient who gives the authorization may revoke that authorization; and
(g) Bear the signature of the patient whose information is to be disclosed, and the date on which the patient signed it.

CONSENT AND AUTHORIZATION

I hereby authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from Golden State Dentistry. I have read and understand this document in its entirety, including the office policies and financial rules of Golden State Dentistry. Without any reservations, I agree to abide by the policy outlined herein.

If any provision of this Financial Responsibility Agreement is held to be invalid or unenforceable for any reason, the remaining provisions of this Financial Responsibility Agreement will continue to be valid and enforceable. If a court or any trier of fact finds that any provision of this Financial Responsibility Agreement is invalid or unenforceable, but that by limiting such provision this Financial Responsibility Agreement, the remainder would become valid and enforceable, then such provision will be deemed to be written, construed, and enforced as so limited.

This Financial Responsibility Agreement encompasses the entire agreement of the parties, and supersedes all previous understandings and agreements between the parties, whether oral or written. The parties have not relied on any representation, assertion, guarantee, warranty, collateral contract or other assurance, except those set out in this Financial Responsibility Agreement, made by or on behalf of any other party or any other person or entity whatsoever, prior to the execution of this Agreement.

_____ _____

Print name of Patient Date

_____ _____ _____

Parent, Guardian or Personal Representative Relationship to Patient Signature of Patient, Parent, Guardian or Personal Representative