DENTAL OFFICE OF TATYANA YASHCHUK, DDS
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WALNUT CREEK, CA 94598
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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 Policy 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 our business office staff.

TREATMENT FEE

Your procedure price includes all required processes and office visits to complete the treatment. This does not cover any work done at any other office or laboratory outside our practice. We provide written estimates for required procedures beforehand. The payment is due at the first visit for the agreed upon procedure, even if completion of the procedure may require multiple office visits. You can ask for the procedure price list from the Receptionist.

We accept cash, money orders, cashier's checks, debit and credit cards. We do not accept personal checks.

DENTAL INSURANCE

The doctors and staff at 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. If, however, your insurance will cover our work, we accept payment for procedures on your behalf from your insurer provided you 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 differ from one insurance company to another and whether our dental providers are in or out of that company's particular network.
- Fees, along with deductibles and co-payments are due at the time of service regardless if the procedure requires multiple appointments.
- After your dental insurance has paid its portion, a statement is sent to the mailing address on record and via email, for any remaining balance. Payment is expected 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. Interest will begin to accrue on any unpaid balance after 90 days.
- Receiving our services indicates your acceptance of responsibility to pay for our services, regardless of our estimate and what 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 **30 days** from the date of the second 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 collections 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.

Interest charges will be applied to all balances not paid within **30 days** of the billing date at a rate of 10% per year. It is your responsibility to ensure your insurance company pays promptly so you can avoid finances charges.

LATE OR MISSED APPOINTMENTS

Our appointments are carefully scheduled around the dentists' 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.

A **24-hour** in advance notice is required if you need to change or cancel a scheduled appointment. Regardless of the reason, missed appointments without at least 24 hours' notice (including no show up appointments), or arriving more than 15 minutes late without notice, will be subject to a **$100** fee for each hour missed or scheduled appointment which will automatically be charged to your account. 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** or email us at **info@goldenstatedentistry.com**.

MINOR PATIENTS

The parent or guardian accompanying the minor is responsible for full payment. 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.

RECORDS AND REIMBURSEMENTS

Original records including radiographs are the property of this office. If you desire, we will provide you with an electronic copy of your record or radiographs to your electronic device (flash card, CD, DVD, or hard drive).

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

This Agreement, along with any exhibits, appendices, addendums, schedules, and amendments hereto, 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 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	Signature of Patient, Parent, Guardian or Personal Representative

_____	_____
Parent, Guardian or Personal Representative	Relationship to Patient