Linh N. Tsai, D.D.S.
1285 Carlsbad Village Drive, Carlsbad, CA 92008
(760)730-3456

PAYMENT POLICY & INFORMED CONSENT

We appreciate your choice in CarlsbaDDS Pediatric Smiles for you child's dental care. At the office of Linh N. Tsai, D.D.S., we value our relationship with your family and would like to offer the following as our payment policy.

Please mark each line as you read along the policies.

☐ If you have dental insurance, we will be happy to help you receive the maximum benefits available under your policy. However, please realize that the relationship is between you, the insured, and your insurance company. If we do not receive payment from your insurance company within six weeks after submission of claim, you will be expected to pay for all dental services in full. In the event of duplicate payments, your account will be reimbursed. ****Please understand that we can only provide an **ESTIMATE** of how much your insurance might pay towards any treatment. A pre-authorization can be done by **REQUEST**, but will delay the treatment by approximately SIX (6) weeks.****

☐ Once the treatment plan and the estimated insurance benefits are reviewed with you, we require that you pay your portion in full at the time of service.

☐ For your convenience, we accept cash, Visa, MasterCard, Discover, and personal checks. There will be a $35.00 service charge for any returned check.

☐ Personal requests for duplicate dental records and x-rays will be assessed a $25.00 service charge. Cancellation of an appointment without **24-hours notice** will be assessed a $25.00 cancellation charge.

☐ When impressions are taken for an appliance, half of the fee is due when the appliance is ordered, and the remaining balance due shall be paid in full when the appliance is delivered.

INFORMED CONSENT

I authorize my insurance company to pay CarlsbaDDS Pediatric Smiles all insurance benefits otherwise payable to me for services rendered. **I authorize** the use of this signature on all insurance submissions. **I authorize** CarlsbaDDS Pediatric Smiles to release health information identifying my child [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1) Patient information related to dental treatment and personal information if responsible party and policy holder required by my insurance company to get insurance claims processed and paid.
2) Dental insurance company for billing my insurance claims. Any other Medical or Dental professionals for referral purposes to continue dental healthcare and ongoing treatment.

I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance and that all payments are due when services are rendered.
I understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of CarlsbaDDS Pediatric Smiles.
I have read and understand the payment policy at CarlsbaDDS Pediatric Smiles.

Name of Patient:
Name of Responsible Party:

Please Sign Electronic Copy
At the Office

Responsible Party Signature Date:

Revised Sept/2009