



LOCATED IN THE:  
DERMIX DENTAL & MEDICAL SPA CENTER  
10719 Riverside Drive Toluca Lake, CA 91602

P: 818.508.7272 F: 818.508.7444

## **Insurance / Financial Policy**

Thank you for choosing Dr Sally Kashani DDS as your dental care provider. We strive to provide the very best service to our patients in every way possible and are highly committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is our financial policy, which we require you to read and sign prior to any treatment.

### **FULL PAYMENT IS DUE AT THE TIME OF SERVICE**

We accept cash, VISA, Mastercard, Discover, American Express, Care Credit and personal check. **There will be a fee of \$25.00 charged on all return checks.**

### **REGARDING INDEMNITY INSURANCE**

Dr Kashani will process most dental insurance claims as a courtesy to our patients. However, we cannot guarantee that your insurance company will pay the “estimated” figure. The balance is your responsibility whether your insurance company pays or not. Therefore, the balance on the account remains always the sole responsibility of the patient. Your insurance policy is a contract between you and your insurance company. We are not a party within the contract. Please be aware that some and perhaps all of the services provided may be non-covered services under your dental insurance policy. All co-pays and deductibles are due at the time of treatment. Please bring all insurance information and cards at first appointment.

### **USUAL AND CUSTOMARY RATES**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. All insurance companies are not the same in what they consider to be usual and customary fees. Please be advised that many times insurance companies pay for the least alternative treatment. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates. We recommend that you take the time to read over your policy and contact your carrier if you have any questions regarding your coverage.

### **MINOR PATIENTS**

The adult accompanying a minor and the parents/guardian of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved payment method at the time of service.

### **INTEREST**

In order to allow us to provide the best quality care and maintain the lowest fees possible, there is a 1.5% finance charge (18% APR) on any unpaid balance carried for more than 90 days.

### **BROKEN APPOINTMENTS**

There will be a \$25.00 minimum charge for any broken appointment or appointment cancelled with less than a 48-hour notice.

***Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns. By signing this, I acknowledge that I have read, understand and agree to the terms of this financial policy.***

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_