WILLIAM J. CHO, D.D.S., M.S.
Diplomate, American Board of Periodontology
Practice Limited to Periodontics and Dental Implants

3144 El Camino Real, Suite 104, Carlsbad, CA 92008 tel 760.720.7372 fax 760.720.7305
e-mail: wjcperio@yahoo.com website: www.wjcperio.com

FINANCIAL POLICY

Thank you for selecting our office for your periodontal care. We are committed to providing the highest level of quality, preventive treatment. Please understand that payment for services rendered is part of your treatment. Outlined below is our financial policy. Please read it carefully and sign below indicating that you understand our policy.

1. Full payment is due at the time of service

2. We accept cash, checks, Visa, Mastercard, and American Express.

3. If you have dental insurance, and you have obtained a pre-estimate, you are expected to pay your portion, and/or deductibles at the time of service.

4. You may elect to pay the entire case fee for all recommended treatment in advance and receive an 8% or senior discount. (Cash or check only). In the event of overpayment a refund will be issued upon completion of treatment. (This option not applicable for dental implant).

5. Missed appointments without a 24 hour notice will be charged at the rate of $100.00. We realize that certain emergencies are unavoidable.

In the best interest of your dental health, your treatment plan will be based on the diagnosis made by Dr. Cho, and you will be informed of the estimated cost of your treatment.

In you have dental insurance; your treatment will not be dictated by available benefits. We will gladly assist you in collecting insurance reimbursement, providing you supply us with a fully completed dental claim form. Upon request, we can obtain a pre-determination of dental benefits prior to treatment. Be aware, however, that a pre-determination is not a guarantee of payment, and that you are directly responsible for the payment of all fees. If your insurance company has not paid your claim within ninety days you will be expected to pay the total balance owed.

Any balance over 90 days will be charged an annual finance fee of 18%. To avoid finance or rebilling charges, we ask that you comply with our financial policy.

I have read and understand the above:

Patient_____ Date_____

Parent or Guardian_____ Relationship_____

PLEASE CONTINUE WITH BACK PORTION

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MEDICAL/DENTAL INSURANCE

MEDICAL INSURANCE:

Primary Policy Holder _____

Insurance Company _____

Insurance Address _____

City _____, State_____ Zip Code_____

Insurance Policy Number _____

Employer _____

Date of Birth _____

DENTAL INSURANCE:

Primary Policy Holder _____

Employer _____

Insurance Company _____

Insurance Company phone # _____

Insurance Address _____

City _____, State_____ Zip Code_____

Insurance Policy Number/ ID # _____

Policy Holder's SS# _____

Date of Birth _____