Amy M. Woo, D.D.S.
2627 K Street
Sacramento, CA 95816

Financial Policy

Thank you for choosing Dr. Amy M. Woo for your dental care. We are committed to providing you with the highest quality dental care possible, but in order to achieve our goals, we ask for your cooperation in being responsible for your dental bill.

YOUR CO-PAYMENT IS DUE AT THE TIME OF SERVICE

We accept cash, checks, Visa, MasterCard, American Express and Discover. Any financial arrangements must be made prior to treatment.

USUAL AND CUSTOMARY RATES (UCR)

Our Usual and Customary Rate (UCR) is based upon the standard of industry for this area. Insurance plans may differ which will affect your dental coverage. Our fees reflect our commitment to the quality patients need to sustain a healthy and lasting oral hygiene.

INSURANCE

As a courtesy to our patients, we will gladly process your insurance claim; however, ultimately you are responsible for any services rendered. Your insurance policy is a contract between you and your insurance company. As a healthcare provider, we are not partial to the agreement made on coverage by your dental insurance plan. Insurance policies vary and services rendered may not be covered. Our office is committed to helping our patients maximize their benefits. We are always available to answer your questions.

MINORS

Payment of services for the treatment of minors is the responsibility of the accompanying adult.

MISSED APPOINTMENTS

Once an appointment has been made, this time has been reserved exclusively for you with appropriate staff to serve your dental needs. Canceling without adequate notice makes it difficult for us to meet the needs of other patients. Missed appointments and same day cancellations (within 48 hours) may incur a charge. The charge helps to keep these problems to a minimum, and in turn, keeps our fees reasonable.

SERVICE CHARGES

It is our policy to charge interest of 1.5% per month (18% Annual Percentage Rate) which will be applied to accounts over 60 days past due. We will charge $25.00 for returned checks.

COLLECTION FEES

Fees incurred from our collection agency will be the responsibility of the patient.

FINANCIAL CONSENT

The patient (or patient's guardian) agrees to be fully responsible for total payment of treatment performed in this office.

I hereby authorize the release of any information relating to my dental claims. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to the office of Amy M. Woo, D.D.S. and the group insurance benefits otherwise payable to me. I understand and agree to this Financial Policy.

____ ________________________

Signature of Patient/Responsible Party Date