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Phone: (925) 830-8809
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GEORGE F. WONG, DDS & GRACE X. WU, DDS, Inc.

OUR OFFICE POLICY REGARDING INSURANCE

It is our office policy to give you, the patient, the best dental treatment and care possible, and we are pleased that you have selected us to take care of your dental needs.

We will be happy to bill your dental insurance company for you at no charge. ***Billing your insurance company for you is a service of this office.*** Ultimately, your dental bill is your responsibility as the patient, whether your insurance company pays your dental bill or not.

If you do have dental insurance, ***it is your responsibility to make sure you do not exceed your yearly maximum.*** If you go over your yearly maximum with your insurance company, the remainder of the bill is, as always, your responsibility. If there are changes regarding your dental insurance, ***our only source on information is from you, the patient. PLEASE KEEP US INFORMED.*** That is the only way we can help you claim what is due for you from your insurance company. Your insurance is a contract between you, your employer and your insurance company.

Even though an insurance claim is filed, you will receive a statement each month your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement or a disputed claim. We will, however, intercede on the patient's behalf in order to assist in the processing of a claim if further ***dental information*** is needed from the provider.

If you do not have dental insurance, you will be required to pay for dental services as they are rendered. If you cannot pay for your dental services all at one time, we do accept VISA or MASTERCARD or can make arrangements for payment for ***no more than a maximum of 90 days.***

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Thank you for letting us take care of your dental needs. We are delighted to have you as a new patient. We look forward to a continued relationship with you.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

_____ DATE: 10/13/2010 9:56 AM

Signature Name of Patient, Parent, or Guardian

_____ DATE: 10/13/2010 9:56 AM

Signature Name of Witness