WELCOME TO OUR PRACTICE!

Dr. Kook is committed to providing you with the best possible care. It is our wish that your visit to our office be as pleasant as possible. If you have dental insurance, we are happy to assist you in submitting claims. Please read the information below and feel free to ask any questions about your treatment or insurance coverage.

We must emphasize that as a healthcare provider, the doctor's relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered and are due at the time services are rendered. We are a zero-balance practice. We do not bill patients; we bill insurance companies as a courtesy.

Your insurance company clearly states, **"a verification of benefits is not a guarantee of payment."** Even if we obtain eligibility before treatment begins, if your insurance company denies or reduces benefits, you are responsible for paying any account balance.

Returned checks are subject to a $35.00 fee. **Patient with balances older than 30 days are subject to 1.5% monthly interest (18% annually) plus all costs of collection, including attorney's fees.**

Our policy is to charge for missed appointments not canceled within 48hrs through our office, not via email or text message. Your insurance will not pay for missed appointments you must pay for them yourself. Our charge is $75.00 for each scheduled appointment hour. Please help us to serve you better by keeping your regularly scheduled appointment.

We accept cash, checks, Discover, Visa, MasterCard, American Express, and Care Credit

If you have any questions about the above information, **PLEASE** do not hesitate to ask us.
WE ARE HERE TO HELP YOU!

Federal regulations require that we offer you a copy of our Policy on Patient Privacy. This policy is posted for you to read and copies are available upon request.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Patient's Name (print clearly) _____

Signature of Patient _____ **Date** _____
(Parent or Guardian if Minor)