Financial Responsibility Statement

Surfside Dental (insert date)

Michael S. McMahan, D.M.D.
2420 Vista Way, Suite 105
Oceanside, CA 92054
760-435-1195

Please read the following financial policies of Surfside Dental:

For Patients without Insurance:
Payment is due on the day of service.
A 10% discount will be given if payment is made on the day of service only.

For Patients with Insurance Coverage:
Insurance policies are a contract between the patient and their insurance company - not between Surfside Dental and their insurance company. For our patients' convenience, we are happy to process claims, and we work to maximize coverage through detailing procedures and communicating with insurance companies. However, ultimately the patient is responsible for all fees, including deductibles, co-pays, non-covered portions or fees, the difference if an insurance company downgrades any procedure, or charges for any procedure denied by an insurance company. Any balance remaining after the insurance has paid are due upon receipt of our statement. In the event that an insurance company has not paid within 60 days from the treatment performed, we will send out a statement for the full amount, and ask that the patient seek reimbursement from their insurance company.

For all Patients:
We understand that some balances may require some time to pay off, and for our patients' convenience we accept cash, personal checks, most major credit cards, and we now offer dental financing through Care Credit. Generally, if the balance will take longer than 90 days to pay off, we ask our patients to consider Care Credit.

If arrangements have not been made to address an outstanding balance after 90 days, we reserve the right to employ outside assistance to collect balances due.

Everyone's time is valuable, and we would ask that if an appointment needs to be cancelled, please be considerate by giving us at least 24 hours notice. We reserve the right to charge patients who chronically cancel appointments a broken appointment charge of $50.

I, (insert name), **have read and understand these financial policies, and accept financial responsibility.**

Patient Name: (insert name) **Date:** (insert date)

(For Minors)
I, (insert name)**, have read and understand these financial policies, and accept financial responsibility for** (insert name)
(Insert name)**:** **Date:** (insert date)