Steven K. Olsen D.D.S., Professional Corporation

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Pil Han, D.M.D.
Michael Hwang, D.D.S.
Renzo Noratto, D.D.S.

---------- *Financial and Insurance Policy* ----------

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial and Insurance Policy is important to our professional relationship.

* All patients must complete the "Patient Information & Medical Form" before seeing the Doctor.
* Full payment is due at the time of service unless other arrangements are made.
* Twenty four hour notice is required when re-scheduling or canceling appointment.
* For your convenience, we accept: CASH, PERSONAL CHECKS, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS.

We also offer Third Party Financing through: Lending Club or Care Credit.

MONTHLY STATEMENTS

A monthly statement with current charges and payments, including insurance billings and payments will be sent to you. Pending estimated insurance benefits will appear on your statement until we receive payment from your insurance company. Billing Fees of 1.5 % per month are added to all unpaid balances after 90 days from date of service.

Should legal action be required to obtain payment, the undersigned patient/responsible party agrees to pay court costs and attorney fees.

INSURANCE ASSIGNMENT

As a convenience to you, we will be happy to submit your insurance claims. The insurance company, not our office, determines the dental benefits that you will receive. The estimated insurance coverage is not a guarantee of payment and is between you and the insurance company. All charges incurred are your responsibility. Please keep your insurance information current by notifying us in writing of any changes in employment, insurance coverage, etc.

I have read, understand and agree to the above. I hereby authorize "Steven K. Olsen D.D.S., Professional Corporation", to submit and to sign insurance claims on my behalf. I hereby authorize the release of any information, pertinent to my case, to my insurance company or their agents. I understand that this authorization is a direct assignment of my rights and benefits under my policy and that payment will be made directly to "Steven K. Olsen D.D.S., Professional Corporation".

Patient / Responsible Party _____ Date _____
SIGNATURE

1/2024