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Phone: 703-273-2545 Fax: 703-273-1116

Financial Policy

Thank you for choosing Laura Y Ki DDS PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from: - Cash, Check, Visa, MasterCard or Discover Card

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care.

Convenient Monthly Payment Options¹ from **CareCredit / Lending Club** Healthcare Credit account

Please note:

Laura Y Ki DDS PC requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received. If you have paid with a credit card, CareCredit, and Lending Club and are requesting a refund you will be charged a 10% processing fee for a charge back.

For plans requiring more than 2 appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans with large Co- payments, a minimum of half payment deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.²

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

A fee of \$40.00 (per 30 minutes) is charged for patients who miss or cancel more than 1 time in a calendar year without 48-hour notice.

Laura Y Ki DDS PC charges \$50.00 for returned checks.

We, our agents or assignees may call by telephone regarding your account. You agree that we, our agents or assignees may place such calls using an automatic dialing/announcing device, to any telephone numbers you have provided. You agree that we, our agents or assignees may, for training purposes or to evaluate the quality of service, may listen to and record phone conversations you have with us and or our agents.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

If my account becomes assigned to a collection agency, I agree to pay a 30% collection fee, interest in the amount of 1.5% per month, court costs and attorney fees, as allowed by law.

Patient, Parent or Guardian Signature (SEAL) Date

Patient Name (Please Print)

¹Subject to credit approval

²However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.