La Jolla Center for Holistic Dentistry

Fen-Hui Chen DDS, FAGD, FICOI, FAAO

IABDM Board Certified Biological Dentist

4510 Executive Drive, Suite 101, San Diego, CA 92121

Phone: (858)459-5445 Fax: (858)459-1146

Financial Arrangements

We will discuss with you the costs of the dental treatments and alternative treatments and various financial arrangements. We will gladly answer your questions until you are completely satisfied.

Dental Insurance:

We will happily assist you by submitting your insurance claim to your dental insurance on your behalf. Dental insurance is a contract between your employer, who selects your coverage limits, and the insurance company. You (the subscriber) will receive the dental benefits as defined within this plan. Insurance payments will be sent to you. If, by insurance company error, the payment is sent to our office it will be credited to your account. **We cannot guarantee insurance carrier payments on reimbursement.**

IMPORTANT: You will be expected to pay the FULL AMOUNT due at the time of service.

Health Care Credit Line Option: ALphaeonCredit and CareCredit

Fee Guarantees and Nonpayment Procedures:

We are obligated by state regulations to be certain that you understand your dental treatment needs, appropriate treatment options, fees involved, and financial arrangements. The estimated fees we provide for dental services are guaranteed for 30 days. Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. You will be informed if this occurs and given the option of continuing treatment or changing treatment.

If your balance becomes 30 days or more overdue, our office reserves the right to interrupt or discontinue dental treatment and/or send your account for collection. If payment is not made within 30 days, your account will be submitted to the collection agency immediately.

In the event that your account is sent for collection, you will be responsible for all costs and fees accrued.

I read and acknowledged all the above policy terms and conditions.

Patient Signature: _____ Date: _____

Printed Name: _____