Allyson A. Abbott, D.M.D.
Christian J. Lehr, D.M.D.
Tina Chou, D.M.D.
Practice Limited to Endodontics

Financial Agreement

Patients with insurance coverage:

1. As a courtesy to you, our office will be glad to help process your claim with your insurance company.
2. You are responsible for full payment of your account. Portions of your bill may not be paid by your insurance company and the balance must be paid by you.

Patients without insurance coverage:

1. Patients that are not covered by insurance are requested to pay for services when rendered. For your convenience payment can be made by cash, check or credit card (MasterCard, Visa, American Express and Discover)
2. If payment in full cannot be made, please make arrangements with our office PRIOR to treatment.

Office Policy

1. A $75.00 fee will be charged for any missed appointments without prior notice.

2. All checks returned from the bank are subjected to a $35.00 service fee.

3. Accounts delinquent more than 30 days from the date of billing are subject to a finance charge per month.

4. Accounts delinquent more than 120 days may be sent to a collection agency for settlement and you will be responsible for any additional fees.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES

Signature____ Date______________________