

**APOPKA DENTAL ART  
LYNE SY TANGCO, D.D.S.**



**WEKIVA CENTRE**

1706 East Semoran Boulevard, Suite 106  
Apopka, Florida 32703  
Tel: (407) 886-8817  
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**OUR FINANCIAL POLICY**

Thank you for choosing us as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

- \*Full Payment is due at time of service.**
- \*We accept Cash, Visa, MasterCard, Discover, and American Express.**
- \* We offer an extended payment plan with prior credit approval thru Care Credit.**

**Regarding Insurance:**

We do accept assignment of benefits; however you are responsible for your percentages up front. **Your insurance policy is a contract between you and your insurance company. We are not a party to that contract, as a courtesy to you we bill your insurance.** If your insurance has not paid within 45 days, the balance will automatically be billed to you. Please be aware that some and perhaps all, of the services provided may not be covered by your insurance, we do our best to find out this information beforehand, and do our best to give you your estimated fees; but sometimes the insurance does not pay even when we've been told they will, this then does becomes your responsibility.

**Usual and Customary Rates:**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Non Sufficient Funds:**

There will be a \$35.00 handling fee for any nonsufficient funds checks.

**Minor Patients:**

The parent or guardian of the minor patient will be responsible for the patient's bill.

**Missed Appointments:**

**Unless canceled, at least 24 hours in advance, our policy is to charge for missed/broken appointments at the rate of \$25.00, per hour of your scheduled appointment.** Please help us serve you better by keeping scheduled appointments. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

**I have read the Financial Policy. I understand and agree to this Financial Policy.**

X \_\_\_\_\_ Date \_\_\_\_\_