

**Dr. Linnea Westerberg, DDS, MS, RN**

**990 Sonoma Avenue, Suite #16 | Santa Rosa CA, 95404 | (707) 571-7890**

**Written Financial Policy**

Thank you for choosing Linnea Westerberg, DDS. 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:**

- Cash, Check, Visa, Mastercard or American Express
- NO INTEREST<sup>1</sup> Payment Plans<sup>2</sup> from Care Credit
  - o Allow you to pay over time with NO INTEREST<sup>1</sup>
  - o Convenient, low monthly payment plans<sup>2</sup> also available
  - o No annual fees or pre-payment penalties

**Please note:**

Linnea Westerberg, DDS requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

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. <sup>3</sup> Any co-payments required by your insurance company are due at the time of service. Since this is an insurance requirement, we cannot bill you for your co-payments at a further date.

Insurance benefits will be estimated based on information obtained from the respective insurance company. Please understand that this is an estimate only and not a guarantee of benefits. Insurance is a contract between you and your insurance company and our office is not a party to this contract. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

A fee of \$75 per hour will be charged to patients who miss or cancel 2 or more appointments without 48-hour notice.

Any returned checks are subject to a \$35 returned check fee.

Patient, Parent or Guardian Signature Date \_\_\_\_\_

Patient Name (Please Print) \_\_\_\_\_

<sup>1</sup>If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

<sup>2</sup>Subject to credit approval <sup>3</sup>However, 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. If insurance requires more than 60 days to process your claim, a finance charge (18% per annum) will be added to any unpaid balance.