Daniel Siriphongs DDS, PLLC
Dr. Daniel Siriphongs – Dr. Hee Jeong
1427 S. Broadway St
Sulphur Springs, TX 75482

Thank you for selecting our office for your dental care needs. We would like to provide you with some basic information about how our office manages appointments, insurance and payment of fees. Please let us know if you require additional information about these topics.

APPOINTMENTS:

Out patients are seen by appointment only. When appointment is made, a treatment room is reserved specifically for that appointment. We confirm all appointments and ask that you be present at your scheduled time. If you must cancel your appointment, we ask that you do so at least 24 hours ahead of time so that your appointment time can be made available to another patient.

PAYMENT OF FEES:

Payments for professional services are due at the time services are rendered unless you have made prior written payment arrangements. Payment may be made in the form of cash, check, Discover, MasterCard, Visa, American Express, or your debit card. Regardless of your insurance status, you are responsible for payment of all treatment fees (covered and non-covered) and any costs, legal or otherwise, which are incurred in the collection of you account balance, should it become delinquent. Delinquent accounts are subject to a 1.5% per month service charge.

INSURANCE (IF APPLICABLE):

Your insurance coverage is a contract between you and your insurance carrier. Your deductible, co-pay and any portion of your treatment not covered by your insurance are due and payable at the time treatment is rendered. After each appointment, you will receive a walkout statement outlining the charges for that appointment and any payments made. After our office has received final payment from your insurance for your treatment, you will be billed for any unpaid balance remaining on your account.

AUTHORIZATION (IF APPLICABLE)

I certify that I am covered by dental insurance, and I assign directly to the dentist all insurance benefits. I understand that I am responsible for payment of services rendered and also responsible for paying everything that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

BY SIGNING BELOW, I AM ACCEPTING RESPONSIBLITY FOR THE PAYMENT OF ANY CHARGES INCURRED IN MY TREATMENT.

_____ _____

Signature of Patient/ Responsible Party Date