Suk young Ahn DDS
DENTISTRY FOR CHILDREN & TEENS

Financial Policy

Thank you for choosing Dr. Ahn for your child's dental needs. Our goal is to create an environment in which you and your child will feel safe and comfortable while we provide you with the highest quality dental care possible. Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA. Please view our financial policies.

- As a courtesy to you, we will bill your insurance. Co-payments are due at the time of service. It is your responsibility to make sure our office is informed of any insurance changes, as well as any changes to address, phone number, etc.
- If your insurance does not pay within 90 days for any reason, you are ultimately responsible for all charges incurred for dentistry performed upon yourself and your dependents in this office.
- Bills are due on presentation. For your convenience, we accept cash, checks, Visa, MasterCard, Discover, Care Credit and debit cards. Payments can be made in the office, by mail, or by calling the office at (530)342-0104. A $25.00 charge will be applied to accounts on any returned checks due to non-sufficient funds.
- If you have financial difficulties please contact the billing desk at (530)342-0104 to establish an acceptable payment plan. Please note that all accounts exceeding 90 days will be assessed an interest charge of 4% a monthly basis unless prior arrangements have been made.
- While the staff here will try to assist with billing problems, ultimately dealing with your insurer and understanding your coverage is your own responsibility. We will inform you if your insurance is "in-network." If not, it is your responsibility to check what your "out-of-network" coverage may be.
- I affirm that the information I have given is correct to the best of my knowledge. I understand that my personal information will be held in the strictest confidence and that it is my responsibility to inform the office of any change in my child's insurance or medical statuses. I authorize the dental staff at Dr. SukYoung Ahn's office to perform any necessary dental services my child may need.
- I certify that I am covered by _____Insurance Co. and I assign to Dr. Ahn all insurance benefits otherwise payable to me. I am also responsible for paying any co-payments and deductibles that my insurance does not cover at time of service. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all my insurance submissions, whether manual or electric. I understand that I am responsible for payment of services rendered.

Signature: _____ Date: _____

Relationship to Patient: _____

Acknowledgement of Receipt of Notice of Dental Materials Fact Sheet

I acknowledge I have received from Dr. SukYoung Ahn's office a copy of the Dental Materials Fact Sheet. I am aware a copy is available upon request.
Signature: _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have read a copy of Dr. SukYoung Ahn's Notice of Privacy Practices. I understand a copy is available upon request.
Signature: _____ Date: _____