Halden S. Yu, D.D.S.
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FINANCIAL POLICY

NON-INSURED PATIENTS:

FULL PAYMENT IS DUE AT TIME OF TREATMENT.

INSURED PATIENTS:

COPAYMENT IS DUE AT TIME OF TREATMENT.

CONSENT FOR TREATMENT

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that I have agreed to accept. I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the doctor and that I am fully responsible for all dental fees. I also assign all dental insurance benefits to the doctor. Any payments received by the doctor from my insurance coverage will be credited to my account or refunded to me if I have paid the fees incurred. I further understand that a late charge of 1.5% per month will be added to any balance 45 days overdue.

Patient:_____ Date:_____

Doctor:_____ Date:_____