

# DR. SAMUEL Y. TOONG, D.D.S., M.Sc.

## ASLEEP FOR DENTISTRY, BURLINGTON

### Financial Arrangements for Dental Treatment

Thank you for your interest in having your dental treatment with us. This document outlines the responsibilities of our office and you as the Financially Responsible Party for the cost of dental treatment we provide to you or someone under your care.

#### Our Responsibilities:

- To provide an estimate for the cost of treatment proposed
- To assist in submission of insurance claims and estimates
- To collect fees due at the time of treatment

#### Your Responsibilities:

- To pay the full amount of the treatment provided at the end of each visit
- To provide us with valid insurance information and subscriber information to help assist in insurance claims. Those with ODSP dental coverage must bring a valid card for the month they are present in our office. There are no exceptions.
- To inform us of any changes to your insurance policy at least 10 days prior to any appointment

Payment is expected at the end of each visit for services rendered. We accept the following methods of payment: **CASH, VISA, MASTERCARD, and INTERAC**. We **do not** accept personal or insurance cheques as methods of payment. Please ensure that you have sufficient funds with your credit card/bank company and that your personal limits are sufficient to complete the transaction.

Patients with dental benefits from the Ontario Disability Program (ODSP) will only be accepted for those who are the primary holder of the ODSP dental benefit. Coverage for spouses and children are not accepted in this office. A valid ODSP Dental Benefits card must be present for each visit. If you do not present one, you will be billed according to our regular fees and fulfil the responsibilities outline in this document. We also **do not** accept insurance from Ontario Works or Dental Care Counts Program. Although Government assisted programs cover most dental treatment, there are a few services that are not covered. If you wish to have these services rendered, it will be your responsibility for the cost.

A copy of the treatment plan will be sent to your insurance company for them to predetermine eligibility and reimbursement. We are not responsible for their accuracy, benefit amounts, limitations and exclusions. Please check with your insurance company if you have questions regarding coverage.

If you have questions or concerns regarding the cost, payment, or insurance claims and estimates, please contact our office so we may attempt to address your needs. We are unable to help patients with financial concerns on the day of treatment and encourage you to discuss any concerns well in advance to your scheduled appointment.

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Every patient is responsible for placing a **\$300.00 refundable deposit**. This deposit is used to secure your appointment. You may also use this deposit towards the cost of your treatment. You will forfeit your deposit for any one of the following reasons:

- Cancellations within 72 hours (3 business days) prior to your appointment or failure to show for your appointment
- Failure to inform us of illness or changes in medical history prior to the appointment
- Failure to follow our fasting guidelines if you scheduled to receive any form of sedation/anesthesia
- Failure to have a someone drive the patient home or provide post-operative care at home
- Failure to provide us with any information resulting in same day cancellations

We take cancellations seriously as patients take time off of work and school to honor their appointments. Please be considerate and inform us in advance if you need to change your appointment.

By signing this document you state that you have read, understand, and agree to abide by the financial terms presented.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness