Robert A. Chong, D.D.S., Inc.
460 Bush St., 2nd Floor, San Francisco, CA 94108
415-681-0668 | chongfamilydentistry@gmail.com

Dear Valued Patient: We at Chong Family Dentistry take pride in our warm, caring atmosphere. One aspect we really enjoy about our practice is the opportunity to offer quality care and individual attention to each and every patient. We like having that personal time with you. When that time is lost due to an appointment cancellation, other patients in need of treatment cannot be seen and your treatment is delayed. For these reasons, we have the following office policy:

Appointment Cancellation Policy

We will make every effort to remind patients by telephone or by texting prior to the appointment but please do not depend on this courtesy. We have found that with the recent popular use of answering machines, cell phones, and voice mail, some of our patients are not receiving our reminder calls due to the occasional malfunction of these devices. If you use such devices, we kindly ask that you return our call to confirm that you received our message. If we are unable to contact you directly, your appointment card or appointment phone call will serve as confirmation of your appointment and it implies your obligation to be present.

Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointments, we require at least 24 hours notice to avoid a $75.00 cancellation fee. If commitments for appointments are frequently broken, a non-refundable reservation fee equal to the appointment fee may be required.

Our ultimate goal is to help you achieve optimum dental health. Broken appointments only serve to delay your dental care and the opportunity to achieve that goal. Thank you for your cooperation. We look forward to seeing you on your next appointment.

Patient Name (Print): _____

Patient Signature: _____ **Date:** _____

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Dental Insurance Policy Acknowledgment

As a courtesy to our patients, we will be happy to complete and file insurance forms relative to dental treatment. **HOWEVER, OUR PROFESSIONAL SERVICES ARE RENDERED TO YOU, NOT TO YOUR INSURANCE COMPANY. THEREFORE, YOU ARE DIRECTLY RESPONSIBLE TO US FOR THE OBLIGATION OF PAYMENT FOR TREATMENT.**

Our fees for services are the same for all patients, whether or not you have a dental program. Your particular program may base its allowance on a fee schedule, which may or may not coincide with our office fees.

There is a great variety in the type of dental insurance coverage offered. Various programs cover from as little as 30% to as much as 80%. Almost every dental plan has a provision for limiting dollar distribution by the insurance company for covered services. Rarely are services covered at 100%.

Please remember, however, the financial obligation for dental treatment is between you and this office and is not dependent upon insurance coverage.

I hereby authorize my insurance company to pay directly to my dentist those benefits accruing to me under my policy. I have read the above and fully understand that I am financially responsible for all charges relative to my dental treatment.

Signature: _____ Date: _____

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Patient Acknowledgement of Receipt

Dental Materials Fact Sheet, October 2001

I acknowledge that I have received from the dental offices of Drs. Robert, Gregory, and Alan Chong a full sized copy of the Dental Materials Fact Sheet dated October 2001 prior to the commencement of any dental restorative procedure as required by Senate Bill #134 signed by the Governor Davis October 2001.

Date: _____ Signature: _____

Acknowledgement of Receipt of

Notice of Privacy Practices

I, _____ have received a copy of the Notice of Privacy Practices.

Print Name

Date: _____ Signature: _____