OFFICE PAYMENT/ FINANCIAL ARRANGEMENT

PATIENT/ RESPONSIBLE PARTY: (Please Print)_____DATE: _____

After a complete initial examination is made and a treatment plan is formulated, an **ESTIMATE** for services to be performed is calculated. If you have any questions regarding any part of your desired treatment or the **ESTIMATED** cost, please feel free to ask or call for clarification at any time. We must make definite financial arrangements before any treatment may be started.

Initial_____ **OPTION #1** - We accept Cash, Checks, MC, VISA and DISCOVER at time of service. Thank you!

Initial_____ **OPTION #2** - Finance your improved Dental Health through a finance company. **CareCredit.com**

Initial_____ **OPTION #3** - Dental Benefits – We diagnose treatment based upon your own needs/desires, as we cannot allow benefit limitations to dictate treatment. We are anxious to help you receive your **legally allowable** benefits. We will gladly discuss your proposed treatment and help you find the answers you may have regarding your benefits. As a **COURTESY** to you, we will be happy to fill out your benefit form. All co-payments and deductibles are due at the time of service via option 1 or 2. At your initial visit, please present accurate benefit information and a completed and signed benefit form, we cannot be responsible for knowing all the limitations of your benefit plan. Dental benefits are a contract between your employer and the benefit company; we are not a party to that contract. The amount of coverage a patient will receive depends upon the quality of the plan purchased by his/her employer, not the fees of the doctor. Please remember regardless of benefits, all fees incurred are the patient's (or guardian's) responsibility. We **do not** predetermine benefits with your benefits company as this is not a guarantee of payment and therefore a waste of time. It only serves to delay necessary treatment and only benefits your benefit company. A Predetermination of benefits fee is $50.00.

Initial_____ **BROKEN APPOINTMENTS** – Failed appointments hurt many people; you, the patient that could have been seen, and our team. Please help us in keeping our fees down by keeping your scheduled appointment time. Unfortunately, appointments broken without 48-hour notice will incur a charge. for hygiene visits the fee is $75.00 and for appointments scheduled with a doctor, the fee will be 50% of scheduled appointment fee.

Initial_____ **TIMELY TREATMENT** – If treatment is delayed by patient, this office is not liable for any increased treatment costs, expenses or loss of teeth.

Initial_____ **RETURNED CHECKS** – There will be a $50.00 returned check fee and if the check is not made payable you could be liable for 3 times the amount of the check (no less than a $100.00 or more than $500.00) - plus the face value of the check and court costs. CALIFORNIA CIVIL CODE CHAPTER 522 SECTIONS 1719.

Initial_____ **DELINQUENCY OF PAYMENT**. I also understand that there will be a finance charge (1.5% per month) for all accounts 30 days overdue and you may be turned over to our collection agency. We realize that temporary financial setbacks may affect timely payment of your account. If such problems do arise, please contact us. I agree to be responsible for reasonable collection costs, court and attorney fees should collection action become necessary.

Initial_____ **AUTHORIZATION**

I authorize my benefit company to pay to the doctor all benefits otherwise payable to me for services rendered. I authorize the use of this signature on all benefit submissions. I authorize the doctor to release all information necessary to secure the payment of benefits. I will not hold my doctor, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I acknowledge I have received a "Dental Materials Fact Sheet dated 10/04". I acknowledge that I have received a copy of this office's HIPAA-Notice of Privacy. I give permission to use my photographs for treatment recording, advertisement uses, and/or education purposes.

Signature_____Date_____

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