FINANCIAL POLICY AGREEMENT

We strive to deliver the finest care possible at a reasonable cost to our patients. We appreciate the trust and confidence you have placed in us, and because we value you as a patient, we want to ensure that you have a clear understanding of our payment policy.

Please review our financial policy below. Our patient service representative will be happy to answer any questions or to address any concerns you may have. After you have read our financial policy and understand it fully, please sign and return it to us with you health history.

Payment is requested at each office visit. We accept Visa, MasterCard, American Express, Discover, personal checks, or cash. You can also pay for your treatment through Chase Health Advance or Care Credit, a third party finance company.

If you have dental insurance, as a courtesy we will file your insurance for you and we will make every effort to assure you receive maximum benefits. We work with almost all traditional plans and several PPO and PDP plans. In order to provide this service, we will need your updated insurance information before each appointment. You are responsible for any deductibles not met; any amounts that exceed your annual maximum allowance and co-payment amounts. If you have any questions regarding your insurance, we ask that you contact your company regarding the specifics and details of your plan.

I agree to allow the office to keep my signature on file and authorize it to submit information on my behalf to the insurance company. I also authorize my insurance company to pay the benefits directly to the office.

In the event that I request a dental procedure that requires more than one office visit (crowns, bridges, dentures, etc.) and I do not return to the office for the completion of the procedure, I will be responsible for payment of the reasonable value for all services actually provided to me plus all laboratory fees incurred by the office.

We require a two-business day advanced notice for any changes or cancellations of your appointment. This allows us the time we initially reserved especially for you in our schedule to be filled by another patient who may have been waiting for this appointment time. We do, however, understand that illness and emergencies occur and we do accommodate for those rare instances. A fee will be charged to your account for not honoring this policy. For an appointment scheduled with our hygienist, we will be charging a fee of $35.00. We reserve time in our schedule for you in advance in order to accommodate your busy schedule. We ask that you give us the same consideration when needing to change or cancel your appointment.

I also agree that, in the event that I do not pay my bill in full within thirty (30) days of its due date, and it is referred to a collection agency, I will be responsible for an additional $35.00 collection fee added to any balances. There will also be a $35.00 fee for returned checks.

Finally, I also agree that a 25% deposit is due at time of appointment scheduling for all surgical procedures with our Specialist Dentist.

Patient's Name (Please Print):

_____ _____

Patient's Signature (or parents/guardians of a minor) Date

Thank you so much for putting your faith and trust in Dr Raul Saenz.

R.S. Saenz, DDS