



CARLOS A. PIEDRA
DENTISTRY

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Welcome to our office!

We believe in optimum communication with our patients; therefore, we ask that you please read the following information and ask any and all questions so we may help you fully understand our financial and appointment policies.

FOR OUR PATIENTS FORTUNATE ENOUGH TO HAVE DENTAL BENEFITS:

Your dental benefits help offset the investment of getting quality dental care performed on you and your family and it is our pleasure to assist you in maximizing your insurance benefits by completing your claim forms. Please be aware that your coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office. Please understand that any assistance concerning what or how much coverage you have, whether by phone or mail, is for reference only and should not be your only basis for proceeding with treatment. We do not base our treatment recommendations on what the insurance company will cover but rather what the best treatment is for you. We will assist you in any way that we can (including electronic claims submission). In addition, because of the inconsistencies in secondary insurance benefits, we do not consider the secondary benefits when figuring your portion of the charges. We will file your secondary claims for you and the payments from your secondary can be assigned to you. We collect estimated portions calculated by our computer system up front; if there is any remaining balance after receiving this portion plus any portion your primary carrier pays, it will be due upon receipt of our statement. If for any reason, we have not received your insurance carrier's payment 90 days after the claim, the remaining balance will be due and payable by you and subject to interest charges (18% APR). Thanks for your understanding.

FINANCIAL AGREEMENT (FOR ALL PATIENTS):

Upon acceptance of treatment in this office the patient/guardian assumes financial responsibility for payment of fees. Treatment is to be paid in full when services are rendered unless other arrangements have been discussed and finalized. This may be in the form of Cash, Check, Visa, MasterCard, Discover or other outside financing. Any balances over 90 days old will be assessed a finance charge of 18% APR. In the event it should become necessary to place your account in the hands of an attorney or collection agency, you will be responsible to pay all costs of collection, including attorney's fees.

REGARDING APPOINTMENTS:

Our time is valuable and so is yours. Our commitment to you is:

- We always try to make appointments that are convenient for you.
- We will not ask you to make a schedule change unless it is an extreme emergency.
- We will always be conscious of your personal time and will try to start your dental appointments on time and complete your treatment as efficiently as possible.

Please understand that **we reserve chair time just for you** when you make an appointment with us. In an effort to continually provide quality service, we ask that you keep your reserved appointment as it is scheduled. Please give our office **48 hours (or more)** notice if you need to change your appointment, or a \$50 fee will be assessed to your account.

Please keep us informed of any changes to your health information as well as your address, phone, email or insurance information so that we may serve you in the best possible manner.

I have read and understand the above financial policies. I authorize release of any information pertaining to treatment for the purpose of comprehensive filing of insurance claims. I authorize payment of primary insurance benefits directly to the dentist otherwise payable to me. I acknowledge full responsibility for the payment of services at the time of service unless other arrangements are made with this office.

X _____
(Patient or Parent or Guardian signature)

(Date)

X _____
(Print patient's name)