CARQUINEZ DENTAL GROUP
FINANCIAL POLICY

Dear Patient:

Thank you for trusting us as your dental care provider. We are happy to have you as a patient and look forward to offering you and your family the finest dental care available. As your dental care provider, we are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. We know that providing comprehensive dental services include discussing all treatment and financial information.

Before treatment is performed, we will discuss treatment and financial options. This will help you to fully understand your dental treatment, what to anticipate in fees, and allow you time to make the necessary financial arrangements.

The following is a statement of our Financial Policy, which we require you to follow prior to treatment:

- All patients must complete our Welcome Packet before seeing the doctor.
- Any deductible or estimated co-payment amount will be due at the time of treatment. For your convenience we accept cash, checks, money orders, and most credit cards. We also offer no-interest payment plans through Care Credit. (www.carecredit.com)

  A returned check fee of $25.00 will be added to your account balance.

Insurance:

Dental Plan benefits are determined by your employer, not your dentist. Your dental plan policy is a contract between you and your plan company. Your plan and payment is your responsibility. A plan is not a guarantee of payment; it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your claim for you if you provide us with all required information.

Usual & Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is considered usual and customary for our area, also known as UCR. UCR is determined based on what providers in the area usually charge for the same or similar dental service.

Minor Patients:

The adult accompanying a minor (parent, guardian, or other adult) is responsible for payment at each visit. For unaccompanied minors, non-emergency treatment will be denied unless other arrangements have been made in advance by the responsible adult. Pre-approved 100% insurance coverage for treatment is also acceptable.

Appointment/Cancellation/No Show Policy:

Appointments are reserved exclusively for you. We kindly ask that if you must change an appointment, please provide us with at least 48 hours' notice. This courtesy makes it possible to give your reserved time to another patient who needs it. Our policy is to charge for appointments at the rate of $50 per hour you were scheduled. Please help us serve you better by keeping scheduled appointments.

Finance Charges:

Finance charges may occur after 90 days on any unpaid balances.

We value all of our patients and encourage any questions and concerns. As always, our promise to you will be to stay at the forefront of clinical excellence, patient care, and service. Thank you for understanding our Financial Policy.

Dr.'s Shafer, Houston, Singh & STAFF

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CARQUINEZ DENTAL GROUP
FINANCIAL AGREEMENT

Responsible Party: ____

Employer: ____

Spouse's Employer: ____

______ (*initial*) I acknowledge that I have received & read the Carquinez Dental Group Financial Policy.

~Please check all methods of payment that apply for your dental care:

( ) **I DO NOT HAVE DENTAL INSURANCE**

_____ I can pay with ( ) ***CASH***, ( ) ***CHECK***, or ( ) ***CREDIT CARD*** on each visit during treatment.

_____ I need to make an extended payment plan with prior Care Credit approval (for longer treatments).

( ) **I HAVE DENTAL INSURANCE**

_____ I can pay my deductible and any portion of the costs that my insurance does not pay on each visit with ( ) ***CASH***, ( ) ***CHECK***, or ( ) ***CREDIT CARD***.

_____ I need to make an extended payment plan with prior Care Credit approval (for longer treatments).

- I understand that it is my responsibility to know my insurance benefit information and that co-payment on dental visits are estimates. ______ (*initial*)

- I understand that I am responsible for all costs not paid by my insurance company and that payment is due within 60 days of the insurance claim submittals. The balance will automatically be transferred to my preferred payment method. ( ) ***BILL MY ACCOUNT*** or ( ) ***CHARGE MY CREDIT CARD.***

CREDIT CARD #: ____

EXPIRATION: __________________ **CVV:** ______________________

SIGNATURE: ____________________________________ **DATE:** ______________________