

Financial Policy

Please review ELIZABETH PATINO, DMD, PA's financial policy. It is important for you to understand it prior to treatment. We welcome any questions you may have.

1. Full payment for treatment provided is due at the time of service. All major credit cards, checks and cash are accepted.
2. Please provide *24-hr notice* prior to changing *any* appointments. There is a *\$70 fee* for failing to keep an appointment or for cancellations without proper notice. We reserve this time exclusively for you.
3. We will gladly copy your dental records for \$35.

Dental Insurance

1. An insurance policy is a contract between you and your insurance company. We are *not* a party to that contract.
2. Your account balance is your responsibility whether your insurance pays or not.
3. In order to accept assignment of benefits, you must be pre-approved on our extended payment plan *or* provide a credit card number with authorization to bill your account for any balance.
4. For your convenience, we will gladly bill your insurance company. Please bring all of your insurance information and any original claim forms prior to treatment.
5. If your insurance fails to pay your account in full within 45 days, the balance will be automatically transferred to your credit card.
6. Please be aware that some procedures may be "non-covered" services and not considered reasonable and necessary under your insurance policy. You are required to pay the full amount charged regardless of your insurance's determination of usual and customary rates or amounts of assignment for these types of services.

Authorization and Release

I certify that I read, understand, and agree to the above information and have had the opportunity to ask questions. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payors. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient
(or Parent/Guardian if minor)

____/____/____
Date

Printed Name

SS#