

## Financial Policy for All Patients of Jose A. Sapia, D.M.D., P.C.

**PAYMENT IS DUE AT THE TIME SERVICES ARE PROVIDED, i.e.,** your deductible and co-payment are due for examinations, dental cleanings and fillings at the time of your appointment. For extensive treatment(s) such as crowns, bridges, implants, dentures, partial dentures and or root canal therapy our office requires one half of the total due at the start of treatment and payment in full when treatment(s) are completed, unless prior arrangements have been made.

### Payment Options

A number of payment options are available to assist you in receiving the treatment you desire. We are happy to work with you to plan the most appropriate arrangements.

#### 1. Cash, Checks or Money Orders

#### 2. Visa, MasterCard and Discover

As a convenience, you have the option to provide our office with a credit card number (fill in below) to be used for your insurance co-payments, as well as transfer of any balance remaining after your insurance claims have been paid.

Please circle:                      VISA                      MASTERCARD                      Discover

Credit Card Number \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_                      3 Digit Code: \_\_\_\_\_

Name as it appears on the card: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_                      Work Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Credit Card Billing Address: \_\_\_\_\_

3. **CareCredit, Citi Health; and LendingClub** - these are companies that offer a line of credit that can cover your entire family's dental needs. Through them we can offer patients charging \$500.00 and more 6 or 12 month interest free options.

### Insurance

Your dental benefits are a contract between you and your insurance company. We are **NOT** a party to this contract. However, we will gladly bill your insurance as a courtesy to you. Your portion of the fee will be based upon available information, is an **estimate only** and is due at the time of treatment. Although we may estimate what your benefits will be, it is the insurance company that makes the final determination of your eligibility and benefits. This may result in a balance after your insurance claim is processed. If you have a balance on your account, we will send you a monthly statement. Payment in full is expected unless prior arrangements have been made. The account is considered past due after 30 days. *It is your responsibility to monitor your benefits and annual maximum.*

### Other Charges

- ❖ We reserve the right to charge a fee for the time lost when a patient fails to provide 24 hours notice to reschedule an appointment.
- ❖ There is a **\$20 Charge** for any check returned to our office unpaid.
- ❖ If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency for non payment, a **Collection Fee** will be added to your account.
- ❖ Should you need copies of your dental records or x-rays, we will be happy to provide you those copies for a processing fee.

Once you have signed this agreement, you agree to all the terms and conditions contained herein.

Signature: \_\_\_\_\_