

Pacific Dental Center Financial Policy

Name of Patient _____ Name of Insured _____

Address _____ City _____ Zip _____

Insured Social Security Number _____ - _____ - _____ Name of Employer _____

Those patients not covered by insurance are expected to pay for the services rendered the day of service. All accounts over 90 days will be subject to an 18% per annual finance charge. Any account sent to a collection service will be surcharged an additional fee of \$25.

For those patients who are covered by an insurance company, we will accept assignment of benefits, which means that you must sign the portion of your insurance form that "assigns" payment to our office. Most insurance plans do not cover 100% of the cost of treatment. Because of this and the extreme delay on receiving payment from the insurance company, you will be asked to pay your deductible and your portion of the charges the day the service are rendered. We will estimate for you, as close as possible, your coverage. Until we receive the payment from your insurance carrier, please understand that we are just giving you an estimate. We will assist you in dealing with your insurance company, but the liability rests with the patient or responsible party. If after 60 days, no payment is received from your insurance carrier, payment in full will be due from patient at that time.

Name of Responsible Party _____

Signature _____

Authorization for Signature on File

Patient Release of information / Financial Responsibility	Insured Assignment of Benefits
<p>I hereby authorize the office of Pacific Dental Center to affix my name to any and all claims and documents as related to any and all benefits due me. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under the applicable law, I authorize release of the information relating to the claim. This "Signature on file" will be valid during my coverage with my insurance carrier. A photocopy of this document may acts as the original.</p> <p>Date: _____</p> <p>Signature: _____</p> <p>Witness: _____</p>	<p>I hereby authorize the office of Pacific Dental Center to affix my name to any and all claims and documents as related to any and all benefits due me and my dependents through my employment with my employer.</p> <p>I hereby authorize payment of dental benefits otherwise payable to me, directly to Pacific Dental Center. This signature on file will be valid while covered with my insurance carrier. A photocopy of this document acts as the original.</p> <p>Date: _____</p> <p>Signature: _____</p> <p>Witness: _____</p>