**FINANCIAL AGREEMENT**

We are committed to providing you with the most comprehensive dental care. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide you excellent service while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 90 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice. In order for our practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Your **estimated** payment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** payment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Third party, extended payment financing is available upon request and approval.

Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

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Print Name of Patient or Responsible Party

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Signature of Patient or Responsible Party Date

**ASSIGNMENT OF BENEFITS AGREEMENT**

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

* Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
* We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.
* We require you to pay the estimated copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an estimate of charges and may be found to be insufficient after review by your insurance company.
* Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 90 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
* Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
* Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

**I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.**

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Print Name of Patient or Responsible Party

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Signature of Patient or Responsible Party Date

**PATIENT MISSED APPOINTMENT AGREEMENT**

We ask when you schedule an appointment that you make every effort to keep that commitment. We understand that personal emergencies sometimes occur, and we always take that into consideration when receiving a last minute cancellation.

If you find that you cannot keep your scheduled appointment, we ask you to provide a minimum of 2 business days notice to us so we may schedule another patient in need of treatment. For your convenience, our office hours are Mondays and Wednesday from 10:00 a.m. to 7:00 p.m., and Fridays from 10:00 a.m. to 6:00 p.m. All cancellations and reschedules must be done by calling the office, it cannot be done by text or email at this time.

It is our policy that with less than 2 business days notice a failed appointment charge of $40.00 or 20% of the scheduled amount, whichever is larger, will be applied to your account. If you have any questions regarding this policy please do not hesitate to contact us. We sincerely appreciate your understanding and cooperation with this matter.

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Patient Signature Date

**NOTICE OF PRIVACY PRACTICES: Acknowledgement of Receipt**

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Dr. Felipe Galvan, Jr. D.D.S. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. Our Notice of Privacy Practices is subject to change.

I acknowledge receipt of the Notice of Privacy Practices of Dr. Felipe Galvan, Jr. D.D.S.

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

(patient/parent/conservator/guardian)

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual’s acknowledgement, describe the good faith efforts made to obtain the individual’s acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

Reasons why the acknowledgement was not obtained:

? Patient refused to sign.

Other or Comments:

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**Dental Materials Fact Sheet**

**Dental Material Data Fact Sheet: Acknowledgement of Receipt**

By signing this form, you acknowledge receipt of the Dental Material Data Fact Sheet dated May 2004. If you have any questions please contact out office at (707) 643-0888.

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

(patient/parent/conservator/guardian)