ENRIQUEZ DMD

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FINANCIAL POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. Financial responsibility on the part of each patient must be determined before treatment.

All dental services including emergencies must be paid for in full at the time services are performed unless other arrangements are made.

Patients with dental insurance are responsible for payment at time of service. However, this office will submit all paperwork required by the insurance company in order to reimburse patients for any amount covered by their insurance policies. Our office will also assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice,
I AGREE TO PAY THE CHARGES FOR THE SERVICES AT THE TIME OF TREATMENT.
I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment in due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I confirm that I have read and fully understand all of the information provided.

By signing below, I acknowledge that I have read this statement and agree to the contents.

Signature of patient, parent, or guardian (responsible party):

Patient's Name: _____ Date: _____

Patient's Signature: _____ Date: _____

Relationship to the Patient: _____ Date: _____