OFFICE FINANCIAL POLICY

Rodney A. Alejandro, D.D.S, P.C.

Welcome to our dental office!

- **Payment in full is due at the time of service**. We accept cash, check, Visa, and MasterCard.
- Your appointment is reserved **exclusively** for you. There is a $40.00 charge for cancellations without 24 hours notice.
- There is a $40.00 returned check charge per returned check.
- Balances 30 days past due and over are subject to a 1.5% monthly service charge. If this account is submitted to our attorney for collection, you agree to pay attorney fees of 33-1/3% of the unpaid balance and finance charges owing, plus all court costs. These terms herein are reaffirmed each time services are received, and you are responsible for services rendered to your spouse and/or children.
- For our insured patients:
  - As a courtesy, we attempt to verify basic plan benefits and estimated co-pays.
  - Verification is **not** a guarantee of payment by the insurance company **or** a release of the patient's legal obligation for any part of our total bill.
  - Plan benefits are complex and unique for each subscriber. As the subscriber, you are responsible for knowing your unique benefits, coverage, and limitations. As your dental care provider, we are responsibility for providing you with the best possible care for your dental needs.
  - **Your estimated deductible and co-pay are due in full at the time of service**.
  - After insurance has determined and paid its benefit, any difference between the estimate and actual amount due will be billed directly to you.
  - As a courtesy, we will file your primary claim for you. You authorize payment of benefits directly to Rodney A. Alejandro, D.D.S., P.C..
- You authorize us to take X-rays, study models, or any other diagnostic aids deemed appropriate to make a thorough dental diagnosis. You further authorize us to perform any and all necessary forms of treatment, medication and therapy in connection with the diagnosis and further authorize us to employ assistance as deemed necessary.

If there is anything we can do to help make your visit more enjoyable, please let us know. We are committed to providing excellent dental care in a patient-friendly office.

Your signature indicates that you have read and agree to our policies above.
As head-of-household or responsible party, your signature indicates acceptance of the aforementioned policies and authorizations for all family members who are current or future patients.

Signature_____ Printed Name_____ Date_____