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Patient Financial Policy

Thank you for choosing Faustino D. Garcia, DMD for your Endodontic care. We sincerely hope that by sharing our financial expectations we will strengthen the practice- patient relationship and keep the lines of communication open.

Patient name____**Date**____________________

General Information

- Your insurance policy is a contract between you and your insurance company. You are responsible for understanding the terms of your coverage and for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or your insurance is terminated, you will be responsible for your balance in full.
- It is your responsibility to resolve disputes between you and your insurance company regarding deductibles, co-payments, covered charges and secondary insurance.
- Your balance is due at the time of treatment.
- While our billing professionals will do all they can to help our patients in communicating with their insurance plan, any questions regarding coverage, benefits or payments are the patient's responsibility to resolve.
- It is your responsibility to notify the office of any change in address, phone, employment or insurance coverage in a timely manner.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action or terminate you as a patient of this practice.

Payment is Due at the Time of Treatment

- We accept cash, checks, credit cards and Care Credit (if you apply and qualify).
- All co-payment, deductibles and non-covered services are due at the time of treatment.

Proof of Insurance

- Please bring your insurance card(s) with you to each appointment.
- We work with most insurance plans. Please check with your insurer prior to your appointment. We do not participate in any Medicare or Medicaid plans, nor do we file insurance in the case of auto or liability insurance. These situations are handled under our Self Pay policy.
- It is your responsibility to provide complete dental insurance information. Claims denied due to the failure to provide accurate and complete insurance information are your responsibility.

I have read the Patient Financial Policy and I agree to abide by its terms.

Patient Signature____**Date**______________________