RENÉ F. CEDEÑO
D.M.D.

FINANCIAL POLICY AND ACKNOWLEDGMENT RECIEPT

CLICK TO SUBMIT

INSURANCE:

1. Patients without insurance are required ***to pay in full at the time of service***. Patients with insurance are required ***to pay any deductible and/or co-payment which is due at the time of service***.
2. Patients who carry insurance should understand and remember that services are rendered and charge to the patient, not the insurance company. We are more than happy to electronically file the insurance benefit claim for you at no additional charge.
3. Any estimate given by this office regarding insurance portion is only a guideline until final insurance payment is received and the patients' account has been reconciled. This office makes no guarantee of the insurance payment as estimated. Any balance not paid by the insurance company is the responsibility of the patient.
4. In the event payment is not made by the due date, a late charge may be added to the patient's account.
5. Any collection fees incurred by this office in an attempt to obtain payment, or bank fees for a returned check, or fees for an appointment messed or broken with less than **24 HOURS NOTICE** will be paid by the patient/guarantor.

PAYMENT OPTIONS:

1. We accept cash, check, credit cards: VISA, MasterCard, Discover Card and American Express.
2. Financing Programs, this includes Care Credit. This is a long-term dental financing program available to patients who qualify. A patient can fill out an application in our dental office, call in their application or fill one out online. If filled out in our dental office, we typically receive an answer within a few minutes.

APPOINTMENT AND BILLING:

Appointment time is reserved specifically for you. Please give us a minimum of 24 Hours Notice of any change needed. This consideration will allow another patient to have the appointment time. Any late cancellation or late rescheduling will result in a $45.00 charge. A billing statement will be sent to you for any balance owed after insurance payment is received. Delinquent account will be promptly referred to a collection agency.

Patient/parent's signature_____ _____ Date _____