OUR FINANCIAL POLICY

We are committed to giving you the ideal treatment. Please understand that payment of your bill is considered a part of your treatment. We depend upon the reimbursement from the patient for costs incurred in their care.

*FULL PAYMENT IS DUE AT TIME OF SERVICE

*WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND AMERICAN EXPRESS

As a service to our patients we will bill your insurance company for you and accept your insurance company's assignment, once your coverage has been verified. **It does not absolve the patient of complete responsibility for the charges in full for the treatment rendered.** All estimated co-payments are due at the time of treatment. Claims are submitted promptly and if not paid by the patient's insurance company within 60 days after treatment will be billed in full to the patient. This office can make no guarantee of the insurance payment until received. **I understand that I am responsible for all cost of my dental treatment.**

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENT:

SIGNED_____ DATE_____

AUTHORIZATION AND RELEASE (INSURANCE ONLY)

I authorize the dentist to release any information including diagnosis and records of any treatment or examination rendered to me. I authorize and hereby request my insurance company to pay directly to the dentist, insurance benefits otherwise paid directly to me.

SIGNED_____ DATE_____

CONSENT FOR DENTAL TREATMENT

I hereby authorize and request Dr. Cruz and her auxilliaries to perform all dental therapy and surgery indicated in my dental records and to do the procedures deemed advisable in her judgement. I will discuss any aspect of my treatment with Dr. Cruz. I acknowledge that the benefits and risk of dental therapy are understood prior to accepting treatment.
I authorize and request the administration of such drugs and/or anesthetics as may be deemed advisable by Dr. Cruz.

I UNDERSTAND THAT ONCE AN APPOINTMENT IS MADE, THAT 24 HOUR NOTICE OF CANCELLATION IS REQUIRED, OTHERWISE A CANCELLATION CHARGE WILL APPLY.

SIGNED_____ DATE_____