



SELF PAY PATIENTS:

FULL payment is due at time of service. **Full payment** for a Complete Treatment Plan of \$300 or more will receive a **5% courtesy discount** if paid at least 3 days prior to your appointment.

Payment arrangements may be made with our Financial Coordinator for full amount of treatment.

All New Patient emergency visits will require payment at the time of service.

INSURANCE PATIENTS:

Patients are responsible for services and payment is expected at the time of service. As a courtesy, we will submit claims to your insurance company. Any time that you receive new dental insurance information you must bring it with you so that our staff can update your chart. You are responsible for paying the bill and following up with the insurance company.

There are thousands of insurance plans and the companies are constantly changing their coverage. It is your responsibility to know exactly what your plan covers. Read your insurance information carefully and call the company to verify benefits. If you do not have your insurance information with you, we expect payment for services at the time of the visit. We accept you as a patient with the understanding that you know your coverage and benefits. Any unanticipated amounts not paid by your insurance company or in the event that your insurance company denies a claim, payment for the date of services are due to our office immediately upon receipt of a statement.

If your insurance company requests information from you, you must respond in a timely manner. Otherwise, the full balance will be your responsibility.

Occasionally, your insurance company may send you a payment. If this occurs, it is your responsibility to submit payment to our office immediately.

PATIENT FINANCIAL RESPONSIBILITY:

Most dental procedures require a portion to be paid by the patient. We **cannot waive** patient portions and must collect them at the time of your visit.

There is a **\$30.00** fee for all returned checks.

CANCELLATIONS/RESCHEDULING APPOINTMENTS:

A **48-hour** (2 business days) advance notice is required to **avoid a fee** of:

- \$85.00** Routine Hygiene appointments
- \$170.00/HR.** Soft Tissue Management or Scaling & Root Planning
- \$170.00/HR.** Any appointment scheduled with Dr Fard or Dr Dary

Consent:

Photographs- I authorize the use of photographs taken of me in any form to be used in any media & to use them to publicize, promote and advertise. _____ Initials

We Value you as a patient and appreciate your cooperation for the future appointments.

I have read and understand the above statement.

I have read the DMFS and Privacy Policy and was given the option to receive a copy.

Print Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian of minor patient
Guardian or coservator of an incompetent patient