In an effort to provide quality care to our patients, we feel it is important to make you aware of our office policies. Knowing this information can help avoid potential problems down the road and facilitate a positive relationship.

Time Commitment & Missed Appointment:

A scheduled appointment is a commitment of time between you and the Doctor/hygienist. We reserve that time just for you. When an appointment is missed or canceled on short notice that time is lost instead of being used by another patient. We make every effort to honor all time commitments and we request of you to extend the same courtesy to us. Our office usually confirms appointments 48 hours in advance. Please advise the office if you need to change your appointment at that time. We reserve the right to charge $50 dollars for appointments missed or canceled without 24 hours prior notice.

Dental Insurance:

We are happy to bill your dental insurance carriers, except EPO, DMO & HMO type, on your behalf at NO charge. The benefits that are actually paid by insurance carriers vary widely from carrier to carrier and group to group and depend primarily on the benefits negotiated and paid for by your employer, union, or other group with the insurance carrier. Very often we can provide you with an approximate estimate of your coverage prior to treatment. However, we can not guarantee the insurance payment as estimated. Hence, **any treatment rendered to you will be your financial responsibility irrespective of what your insurance pays.** With your signature (below) you accept our policy and authorize Hanette S. Gomez DDS to 1) bill your insurance carriers on your behalf: 2) release any information regarding treatment at this office to your insurance carriers: 3) authorize payment directly to Hanette S. Gomez DDS any insurance benefits due to service rendered.

"If you are presently covered by a Dental Insurance Plan, and have received notice of any termination, Suspension or other Interruption in your employment or union affiliation, or information about your "deductible" (your personal liability) levels, such may affect your insurance coverage for dental or other medical services. It is solely your responsibility to verify coverage to avoid personal financial liability. This office will not verify coverage before each treatment, and will hold you liable should insurance be denied".

Payment Options:

Payment is required on the day of your appointment. If you have dental insurance, your estimated co-payment and deductible are due on that day.

For your convenience, we accept cash, check and all major credit cards (Visa, MasterCard, American Express, Discover, and Debit Cards). Furthermore, our office offers easy to use financing programs through several finance companies. One of our programs offers 12 months same as cash option and no penalty for early payoff. You may

use our finance program for all or part of your procedure (over $1000).

How do you plan on paying for your treatment?

Cash ☐ Check Credit Card ☐ Finance program ☐

Practice dismissal

Occasionally, we may find it necessary to dismiss a family from the practice. Reasons for this include, but are not limited to, the following: recurrent late or missed appointments; noncompliance with recommended medical care; nonpayment of bills; threatening, abusive, or rude behavior toward office staff, doctors, or other patients and families. Knowing this information in advance will save you frustration, inconvenience and possibly money! We want to help you obtain the best quality and most cost-effective services possible.

Notice of Privacy Practices

Our office obeys federal and state law regarding the privacy of your health information. With your signature below you Acknowledge the Receipt of our office's Notice of Privacy Practices (you may refuse to Sign This Acknowledgment).

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the dentist at the next appointment without fail. By Signing below I also agree to be responsible for payment of all services rendered/ and canceled appointments to the patient named above.

I am the: Adult Patient Parent Guardian

Signature: ________________________________ Date: ____________________