

MICHAEL J. BRISENO, D.D.S.

OFFICE POLICY

THANK YOU FOR CHOOSING US AS YOUR DENTAL CARE PROVIDER. WE ARE COMMITTED TO YOUR TREATMENT BEING SUCCESSFUL. BELOW IS OUR OFFICE FINANCIAL POLICY, THE POLICY MUST BE READ, INITIALED AND SIGNED PRIOR TO ANY DENTAL TREATMENT.

Our office, **EFFECTIVE IMMEDIATELY** will start collecting a **\$5.00 Infection Control fee** per patient per office visit. _____ **Initials**

PAYMENT TERMS/TYPES:

FULL PAYMENT IS DUE AT THE TIME OF SERVICE (UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE AND APPROVED BY THE DOCTOR)

ALL PATIENTS ARE DIRECTLY RESPONSIBLE FOR ALL CHARGES INCURRED

WE ACCEPT THE FOLLOWING PAYMENT TYPES:

CASH, CHECKS, ALL MAJOR CREDIT CARDS AND CARE CREDIT

If a check payment is returned, there is a \$45.00 fee assessed and all payments must then be made by Cash, Credit Card or Money Order.

INSURANCE COVERAGE

- ANY DIFFERENCE BETWEEN TREATMENT, COST & YOUR ESTIMATED BENEFITS IS DUE PRIOR TO TREATMENT. HOWEVER, WE CAN MAKE NO GUARANTEE OF ANY ESTIMATED BENEFITS. ANY DIFFERENCE FROM THE ORIGINAL TREATMENT PLAN ESTIMATE AND WHAT YOUR INSURANCE COMPANY PAID WILL BE INVOICED OR CREDITED UPON RECEIPT OF THE FINAL INSURANCE PAYMENT. _____ **Initials**
- SECONDARY INSURANCES- ALL PAYMENT FOR TREATMENT MUST BE PAID WITHIN **(90) DAYS** FROM THE DATE OF SERVICE BY THE RESPONSIBLE PARTY.
- FOR INSURANCE COVERAGES WHERE WE ARE A PARTICIPATING PROVIDER, ALL CO-PAYMENTS ARE DUE AT TIME OF TREATMENT.
- REGARDLESS OF ANY INSURANCE COMPANIES ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES, ALL PATIENTS ARE ULTIMATELY RESPONSIBLE FOR ALL CHARGES.

MINOR PATIENTS

ALL MINOR CHILDREN MUST BE ACCOMPANIED BY AN ADULT PARENT OR GUARDIAN PRIOR TO INITIAL TREATMENT. THE PARENT OR GUARDIAN IS RESPONSIBLE FOR ALL CHARGES.

BROKEN/MISSED APPOINTMENTS

BROKEN APPOINTMENTS WILL BE CHARGED \$25.00 WITHOUT 48 HOUR NOTICE! _____ Initials

We understand EMERGENCIES happen, but please let us know ASAP.

PLEASE DO NOT MAKE ANY APPOINTMENTS IF YOU ARE NOT SERIOUSLY COMMITTED TO IMPROVING YOUR DENTAL HEALTH!

I HAVE READ THIS FINANCIAL POLICY, I UNDERSTAND AND AGREE TO THESE TERMS.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

DATE