JANETTE PINEDO DDS, INC.
Written Financial Policy

Thank you for choosing Janette Pinedo DDS, Inc. We would like to welcome you to our practice. Our mission is to deliver the best and most comprehensive dental care available, and our goal is to make the cost of optimal care as easy and manageable as possible to all our patients.

IF YOU HAVE DENTAL INSURANCE COVERAGE:

The processing of a patient's dental insurance claim and accepting the assignment of benefits to minimize out of pocket expenditure is a courtesy that is offered to patients with an understanding that they are ultimately responsible for their estimated share of cost. However, we must emphasize that as a dental provider, our relationship is with you and not your insurance company.

___ I hereby authorize my insurance company to pay directly to my dentist under the terms, provisions and exclusions of my policy.
___ I am aware that not all services are a covered benefit with all insurance plans and that I am responsible for payment of all dental services rendered.
___ It is my responsibility to inform you of any changes to my dental insurance policy so that my coverage can be check prior to my appointment.

BY SIGNING BELOW YOU CONFIRM THAT YOU HAVE READ AND UNDERSTAND THIS POLICY:

___ It is my responsibility to inform your office of any address or telephone number changes
___ My account is to be kept current and I understand payment is expected at time services are rendered.
___ I understand that Janette Pinedo DDS, Inc. accepts personal checks, cash, all credit cards, money order.
___ I understand that a fee of $25 will be charged on all returned checks.
___ I understand that a service charge of 1.5% (18% per annum) will be charged on all balances not paid within 60-days of the treatment date.
___ I am responsible for all collection costs, attorney's fees and court costs related to the collection of any outstanding balance on my account

I agree that a waiver for any breach of any terms or conditions hereunder shall not constitute a waiver of any further terms or conditions.

I grant permission to you or your assigns, to telephone me to discuss matters relate to this form. I have read the above conditions of treatment and agree to their content.

_____ _____
Patient's Signature (If minor, Parent or Legal Guardian) Date

_____
Patient's Print Name (If minor, Parent or Legal Guardian)