OUR OFFICE POLICIES

X-RAYS AND EXAMINATION

I authorize *Dr. Novara Dr. Rico* to perform dental examination, take all x-rays, and all photographs required to properly diagnose my dental health and provide an effective treatment plan. _______ Initials

I authorize Doral Family Dental to share my x-rays, pictures, and/or models with others for teaching and/or marketing purposes. All identifying information will be removed. _______ Initials

I authorize Doral Family Dental to send me emails/text messages regarding my appointments or promotions_____________Initials

APPOINTMENTS

Please be aware that we reserve the right to charge *$50.00* to your account for appointments cancelled or broken without a minimum notice of 24 hours. Also deposits made to hold appointments are non- refundable. _______ Initials

INSURANCE

As a courtesy to our patients, we are providers for some dental insurance companies. Most policies do not cover 100% of the cost of your treatment. We will estimate your coverage as closely as possible, based on information we receive from your insurance company, but until we actually receive payment from them, it is just an estimate. I acknowledge responsibility for payment of services rendered on my behalf. I also authorize the office of *Dr. Novara / Dr. Rico* to file all claims pertaining to my treatment. I authorize my signature to be on file for all insurance claims. **If my insurance plan does not cover completely the cost of my care within 45 days, I acknowledge full responsibility for payments pertaining to my treatment.** _______ Initials

PAYMENTS

Payment is due at the time services are rendered. **Patients are expected to pay in cash, VISA or MASTERCARD. <u>SORRY, WE DO NOT ACCEPT PERSONAL CHECKS.</u>** We also have various companies that offer payment plans (Citicard, Carecredit and Chase). These plans only take a few minutes to apply and allow you to start treatment today and spread payment over time.

Should it be necessary to collect my account through an attorney or collections agency, I hereby agree to pay all costs of collections, all attorney fees, court costs, and any other costs related to the collection of my account.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

____
Patient's Name

____ _________________
Signature of Patient or Responsible Party Date