Thank you for selecting us as your personal dental care team. To promote a long-term mutually satisfying relationship, we would like to explain our office policy regarding ***treatment, insurance, appointments, and fees.*** *Please read this carefully and ask any questions or bring up any concerns you may have* ***before*** *treatment is rendered. Submission to treatment implies your consent to the terms of this agreement.*

TREATMENT

You will find our entire staff is dedicated to helping you improve your dental health as quickly as possible. Every effort will be made to make your appointment as comfortable and pleasant as possible. Please feel free to discuss your treatment with the doctor at any time.

INSURANCE

If this office is able to accept your insurance company's assignment, the patient (or designated responsible party for the patient) is still FULLY RESPONSIBLE for the charges for treatment rendered. Your insurance may NOT COVER the services or may only PARTIALLY cover them. Any estimate given by this office is considered a GUIDELINE until the final insurance payment is received and the patient's account is reconciled. This office can make NO GUARANTEE of actual payment by your insurance company.

PAYMENT IS DUE AT THE TIME OF SERVICES

We accept cash, personal checks, Master Card, Visa, Discover, American Express, and Care Credit. When insurance applies, we will collect any deductible and estimated co-payment at this time.

LATE CANCELLATION POLICY & MISSED APPOINTMENTS

When we schedule your appointment, the time is reserved exclusively for you.

We request that you give us at least 24 hours' notice (1 business day) when you realize that you cannot keep an appointment. When the requested notice is not given, your account may be charged $50 for failing, cancelling, or rescheduling an appointment without notice of at least 1 business day.

FEES AND SERVICE CHARGES

1. MONTHLY BILLING: Even though an insurance claim has been filed, you will receive a statement each month if there is a balance due on your account, since you, not the insurance company, are responsible for payment of your account.
2. RETURNED CHECK: There is a $25.00 fee for returned checks. Remittance of the check must be paid to cover the original amount and the check fee.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET (2) & RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices and Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding these Notices. _____ (Initials)

_____	_____	_____
Print Patient/Parent/Guardian Name	**Patient/Parent/Guardian Signature**	**Date**

Francisco Mondragon, DDS

180 Otay Lakes Road. Suite 206. Bonita, CA 91902. Main: (619)475-8222 | Fax: (619) 773-7757