Patient Name: _____ **Birthdate:** _____ **Date:** _____

Dennis A. Hernandez, D.M.D., P.A.
FINANCIAL POLICY and CONSENT FORM

Thank you for choosing our office for your dental needs. It is our goal for patients to clearly understand their treatment as well as their financial responsibility. Please read the following carefully and sign and initial where indicated.

Consent for Treatment: I hereby authorize the Dentist to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Dentist to perform any and all forms of treatment, medication, treatment that may be indicated. I also understand that the use of anesthetics embodies some risks. **Initial:** _____

Guarantee of Payment: I fully understand that I am directly responsible for payment to the Dentist for all dental services rendered to me. I also understand that all bills are payable and become due at the time services are rendered. All outstanding balances are subject to a finance charge of 1.5% monthly (18% annum) after 60 days. **Initial:** _____

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. A fee of $35 is charged to patients who miss or cancel more than 1 time without 24-hour notice.
* **Initial:** _____

Returned Checks: Dennis A. Hernandez DMD, PA charges $35 for returned checks. **Initial:** _____

I have read and fully understand the office financial policies and agree to its content.

Signature: _____ Date: _____

INSURANCE PATIENTS

The treatment recommended by our practice is never based on what your insurance company will pay, as your oral healthcare and accompanying treatment should not be governed by your insurance company contract.
Our office accepts all private and most PPO dental insurance plans. The amount of money each insurance plan will pay entirely depends on the specific dental plan and type of coverage you and your employer selected. Thus it should be understood that the dental insurance contract is between the insurance company and the patient. Most plans have exclusions and limitations which will affect reimbursement. Please make yourself aware of your plan's exclusions, limitations, yearly deductibles, waiting periods and patient/family maximums.
As a courtesy, our office does its best to verify the coverage that your particular plan provides. However, as stated by the insurance carrier, any information given is not a guarantee of coverage until the bill is submitted and processed. Therefore, we are pleased to **estimate** your benefits and submit claims for payment for services rendered to your insurance company. Our staff will assist you in obtaining your maximum dental insurance benefits. Although we work very hard to be as accurate as possible with our estimates, due to the sheer number of plans and their diverse benefit options, our estimate is just that, an estimate.

Authorization to Release Information: I hereby authorize the Dentist to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim. **Initial:** _____

Assignment of Benefits: If the insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the office of Dennis A. Hernandez DMD, PA. I also understand that I am financially responsible for any charges not covered by my insurance company. **Initial:** _____

Guarantee of Payment: I understand that I am responsible for any deductible and the estimated portion of my copay at the time services are rendered. If payment is not received from the insurance company within 60 days after date of service the entire balance is due. **Initial:** _____

I have read and fully understand the office financial policies and agree to its content.

Signature: _____