



## Financial Policy

Our office is committed to providing you with the best possible care. If you have dental insurance we are anxious to help you receive your maximum benefit allowed and we will be happy to process your insurance claim form for you. In order to achieve these goals we need your assistance and understanding of our office payment policy.

**Payment is due at the time services are rendered** unless other prior payment arrangements have been made with the office manager. A duplication fee may apply to X-ray duplication requests. For your convenience we accept **cash, checks, credit cards**. Returned checks and balances older than 30 days may be subject to additional collection fees and or interests charges. Charges may also be applied for broken appointments that are not canceled within 24 hours advance notice.

Due to the constant changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize that:

1. **Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract.**
2. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will cover and they will also establish their own fee schedule for a service. We do not participate with any fee schedule.

As a courtesy, we will file your insurance claim and accept assignment of benefits-providing we have the following authorization.

**In the case that the reimbursement is not as much as estimated, you are denied benefits, or the insurance company did not pay within 60 days of submission, I authorize Patricia Pavlos, DDS to keep my confidential signature on file and to charge my credit card for the balance of any charges not paid by the insurance company or myself within 60 days of treatment.**

### Account Type

Circle: VISA    MASTERCARD    AM EX    DISCOVER

Cardholder Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
\_\_\_\_\_ zip code \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_ / \_\_\_ / \_\_\_

CVV 3 digit code (on back): \_\_\_\_\_ (Amex 4 digits on front)

Signature: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_