



Camino Dental Group

Financial Policy

Patient Name: _____

Today's Date: ___/___/___

Guarantor's Name: _____
(Name of guarantor or responsible party)

Relation: Spouse Child Other _____

ID#: _____

Identification Type: _____

Staff: _____

Terms and Condition

Dental health is an investment in an individual's well being. We believe that financial considerations should not stop you from getting the treatment that you require. Therefore, we provide different options for payment. We accept Visa, Master Card, cash, and check accompanied with a valid proof of ID. We are also pleased to offer Dental Fee Plan through Capital One.

ON FEES AND PAYMENTS:

Payment is expected at the time of service. Fees are subject to change with prior notice before treatment. Balances remaining beyond 30 days from billing will have a late payment charge of \$20 and accrue a monthly interest at a rate of 10% APR. There is a \$35 processing fee for returned checks, and a \$25 fee for broken appointments without 24-hour notice.

ON DENTAL INSURANCE:

We accept most PPO dental insurances. Co-payment is expected at the time of service. The insurance policy is an agreement between you (the patient, or patient's employer), and the insurance company, not between the insurance company and this office. The insurance does not guarantee benefits over the phone or on the web. Therefore, it is the patient's responsibility to understand his/her insurance policy prior to treatment. Insurance benefits are subject to change based on condition of employment, change in benefit coverage or non-coverage, or change in patient status. If your insurance pays for an alternate benefit, you will be responsible for the difference between the fee for the actual procedure and the alternate procedure fee. If your insurance does not pay in full for any reason, you will be responsible for the remaining balance of the treatment.

Estimate does not include fees charged by specialist. If you saw a specialist within this benefit/calendar year, then your benefits may have been reduced.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event of default, I promise to pay legal interest on the indebtedness, collection costs, and related attorney's fees.

Signature of Patient / Guarantor if minor

Date

Assignment of Benefits: Authorization and Release

I hereby authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail as a follows:

Camino Dental Group
1328 W. El Camino Real Suite #1
Mountain View, CA 94040

I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, and for any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Signature of Patient / Guarantor if minor

Date