Carlos E. Sanchez D.D.S

2160 W. Grant Line Road
Suite 210
Tracy, CA 95376

Tel: (209) 836-4277
Fax: (209) 836-4107

Financial Policy

Patient Name: _____

Cash Patient

Full payment at time of service is expected. We accept cash, check, Visa, Mastercard, American Express and ATM.

Note on Insurance

We will assist you in obtaining maximum benefits from your plan and file your claim for you providing you submit to us all the necessary detailed information required for reimbursement. We will not enter into a dispute with your insurance company, but will resubmit your claims, if requested by you. We will **estimate** your portion of the bill that is not covered by insurance. This estimated amount is due at the time of service. Should your insurance company deny or not cover the charges incurred during your visit, you are responsible for all said charges. (It is also the responsibility of the patient to know which referring dentist or specialist your insurance is contracted with, so that your visit is comfortable and paid correctly).

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT: I Authorize treatment of the person named above and agree, irrevocably, whether signing as agent or as patient, that in consideration of the service to be rendered to the patient that I hereby individually obligate myself to pay the account in accordance with the regular rates and terms of the provider. I hereby give authorization for payment of insurance benefits directly to provider named above, and any assisting physicians for services rendered. As required by law, you are hereby notified that a negative credit report reflecting on your credit record may be submitted to a credit-reporting agency if you fail to fulfill the terms of your credit obligation. Should the account be referred to an attorney or collection agency for collection, the undersigned agrees to pay actual attorney's fees and collection expenses. It is agreed that payments will not be delayed or withheld because of any insurance coverage of the pendency of claims thereon, and all proceeds of insurance of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as a valid as the original.) Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of the usual and customary rates. A $25.00 fee is charged on all returned checks. A 1.5% service charge will be assessed on all accounts not settled within each 30-day cycle after determination of patient responsibility. **In addition to cash or check, Visa, MasterCard, Discover and Debit cards are accepted**.

RELEASE OF INFORMATION: The provider may disclose all or part of patient's records to any person or corporation which is or may be liable under a contract to the provider or to the patient, family member, or the employer of the patient of the family member for all or part of the providers charge, including but not limited to, medical service companies, workman's compensation carriers, welfare funds, or the patients employer. I further authorize my employer to release employment information to the provider or the provider's agents.

SIGNATURE _____ DATE _____