

# FINANCIAL CONTRACT

## PATIENT:

NAME: Mr. Mrs. Miss Dr. First MI. Last BIRTHDATE: \_\_\_\_\_ Month Day Year

## INSURANCE PROVIDER:

POLICY HOLDER NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ Month Day Year  
First Last

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_ HOME PHONE #: (\_\_\_\_) \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_  
Street  
City State Zip Code

WORK PHONE #: (\_\_\_\_) \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ TYPE (I.E. PPO): \_\_\_\_\_

GROUP OR POLICY #: \_\_\_\_\_ INSUR. PHONE #: (\_\_\_\_) \_\_\_\_\_

**NOTE: PLEASE NOTIFY THE OFFICE MANAGER IF THERE IS A SECONDARY INSURANCE PROVIDER.**

## OFFICE FINANCIAL TERMS:

1. PAYMENT IS DUE AT THE TIME WHEN SERVICES ARE RENDERED. PATIENT INITIALS: \_\_\_\_\_
2. THIS OFFICE ACCEPTS CASH, CHECK, VISA, MASTER CARD, AMERICAN EXPRESS, AND CARE CREDIT.
3. THE OFFICE WILL SEND A STATEMENT ONLY IF AN INSURANCE PROVIDER PAYS LESS THAN ESTIMATED.
4. FULL PAYMENT OF A STATEMENT AMOUNT IS DUE 20 DAYS AFTER THE BILLING DATE OF THAT STATEMENT.
5. LATE PAYMENTS WILL ACCRUE MONTHLY FINANCE CHARGES EQUIVALENT TO 18% ANNUALLY (18% APR). PATIENT INITIALS: \_\_\_\_\_
6. ACCOUNTS WITH PAST DUE BALANCES BEYOND 90 DAYS WILL BE TURNED OVER TO A COLLECTIONS AGENCY.
7. ALL APPOINTMENTS WHERE TREATMENT COSTS \$500 OR ABOVE WILL REQUIRE A \$50 NON-REFUNDABLE DOWN PAYMENT.
8. A BOUNCED CHECK WILL BE SUBJECT TO A \$50 PROCESSING FEE. A CHECK WILL THEN NO LONGER BE ACCEPTED AS PAYMENT.
9. THERE IS A \$50 FEE FOR EACH MISSED OR RESCHEDULED APPOINTMENT WHEN 48 HOURS NOTICE IS NOT GIVEN. PATIENT INITIALS: \_\_\_\_\_

THIS NOTICE CANNOT BE LEFT ON THE ANSWERING MACHINE, NOR CAN IT BE GIVEN OVER THE WEEKEND.

## INSURANCE POLICY TERMS:

1. I PERMIT THIS OFFICE TO CONTACT MY INSURANCE PROVIDER(S) TO ESTIMATE MY BENEFITS AND TO SUBMIT CLAIMS FOR ME.
2. I AUTHORIZE MY INSURANCE PAYMENTS TO GO DIRECTLY TO MURRIETA DENTAL CARE.
3. I KNOW THAT THERE MAY BE AN ANNUAL DEDUCTIBLE FEE THAT I MUST PAY BEFORE MY INSURANCE PROVIDER(S) WILL PAY CLAIMS.
4. I AM AWARE THAT INSURANCE PROVIDERS PAY ONLY A PERCENTAGE OF EACH PROCEDURE. I MUST PAY THE REST.
5. I UNDERSTAND THAT THERE IS AN ANNUAL MAXIMUM OF INSURANCE PAY OUT. I MUST PAY ALL CHARGES BEYOND THIS MAXIMUM.
6. I ACCEPT THAT MY INSURANCE PROVIDER(S) MAY DENY MY CLAIMS. I AM RESPONSIBLE TO PAY FOR ALL SERVICES RENDERED.

SIGNATURE OF RESPONSIBLE PARTY: \_\_\_\_\_ DATE: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_ OFFICE INITIALS: \_\_\_\_\_