

# FINANCIAL CONTRACT

## PATIENT:

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

## INSURANCE PROVIDER:

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

SOCIAL SECURITY #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_ BEST 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 THE 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. A BOUNCED CHECK WILL BE SUBJECT TO A \$50 PROCESSING FEE. A CHECK WILL THEN NO LONGER BE ACCEPTED AS PAYMENT.
8. THERE IS A \$50 FEE FOR EACH MISSED OR RESCHEDULED APPOINTMENT WITHOUT 2 BUSINESS DAYS NOTICE. PATIENT INITIALS: \_\_\_\_\_

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

## INSURANCE POLICY TERMS:

1. IF I HAVE ANY INSURANCE CHANGE OR CANCELATION, THEN I AM RESPONSIBLE FOR PROMPTLY NOTIFYING THIS DENTAL OFFICE.
2. I PERMIT THIS OFFICE TO CONTACT MY INSURANCE PROVIDER(S) TO ESTIMATE MY BENEFITS AND TO SUBMIT CLAIMS FOR ME.
3. I AUTHORIZE MY INSURANCE PAYMENTS TO GO DIRECTLY TO MURRIETA DENTAL CARE.
4. I KNOW THAT THERE MAY BE AN ANNUAL DEDUCTIBLE FEE THAT I MUST PAY BEFORE MY INSURANCE PROVIDER(S) WILL PAY CLAIMS.
5. I AM AWARE THAT INSURANCE PROVIDERS PAY ONLY A PERCENTAGE OF EACH PROCEDURE. I MUST PAY THE REST.
6. I UNDERSTAND THAT THERE IS AN ANNUAL MAXIMUM OF INSURANCE PAY OUT. I MUST PAY ALL CHARGES BEYOND THIS MAXIMUM.
7. 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: \_\_\_\_\_