JR GONZALEZ, D.D.S., P.A.
Aesthetic and Restorative Dentistry

FINANCIAL POLICY

Thank you for choosing Dr. JR Gonzalez as your dental care provider. We are committed to providing you with the highest quality of dental care utilizing only the best materials and education available. Anything we do or say will be centered on this philosophy. We are committed to your treatment being successful, and payment of your bill is considered part of that treatment. The following is our **Financial Policy**, which we ask you read, initial, and sign prior to treatment.

_____ **PAYMENT FOR SERVICES RENDERED:** Patients are responsible for payment of all services rendered on their behalf or their dependents. Payment is due at the time of service unless other financial arrangements have been made in writing in advance. Our office accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Outside financing is available.

_____ **INSURANCE ASSIGNMENT:** We may accept assignment of insurance benefits; however, most insurance plans do not cover 100% of the fees charged and have a deductible, which must be satisfied before any insurance benefits can be received. Also, please keep in mind that some, and perhaps all, of the services may not be considered reasonable and necessary under the provisions of your insurance plan. We require that all deductibles, co-pays, and/or any percentage of the bill that the primary insurance carrier does not cover, be paid at the time of service. Furthermore, any outstanding balance not paid by the primary insurance company will be the responsibility of the patient. If your insurance company has not paid your balance in full within 60 days, the balance will automatically be transferred to your account, and you will be responsible for the balance owed. This office cannot render services on the assumption that our fees will be paid by your insurance company. **We must emphasize that as your dental care provider, our relationship is with you, our patient, and not with your insurance company. Your insurance plan is a contract between you, your employer, and the insurance company. Our office is not a party to that contract or any possible restrictions.**

_____ **CANCELLED AND MISSED APPOINTMENTS:** Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all of our patients. In return, we ask that patients make every effort not to miss or change reserved dental appointments. If you find that you are unable to make or must change your reserved dental appointment, we require a **minimum of 24 hour** notice. A **$75** fee will be charged for cancelled and missed appointments on the **second and subsequent cancelled offense as well as for multiple 24 hour notice cancellations.**

_____ **DEFAULT ON PAYMENT:** In the event of default on payment **at or after 60 days,** your account will be turned over to an accounts receivable collections company and the patient or guardian promises to pay a service fee in the amount of **$25** in addition to the balance owed.

Responsible Party Signature _____ Date _____