FINANCIAL POLICY

We are committed to providing you with the best care possible, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

Payment is due at the time services are rendered.

Acceptable Methods of Payment:

1) We accept cash, checks, and most major credit cards.
2) We also offer interest free financing for qualifying patients, thru **Care Credit.** Approval usually takes less than 10 minutes and no payment is needed to start treatment.
3) For Patients without Insurance: We offer a 5% account reduction if payment is made in full prior to treatment with either cash or check.

Insurance:

As a courtesy to our patients with insurance we will bill your insurance company for you. We are not the insurance company and therefore DO NOT guarantee any benefit coverage.. We do our best to give you accurate estimates provided to us by each plan. Please understand these are only estimates and may not be accurate due to insurance terms, eligibility and clauses. If your insurance has not paid their estimated portion within 30 days or has denied your claim, you must be prepared to pay the full amount due. All claims submitted are subject to review and vary with each individual plan. For more specific details please refer to your insurance information book.

All checks returned for any reason will be assessed a $45 service charge.

Finance Charges:

All balances 31 or more days overdue will be subject to a finance charge of 1.5% per month (18% APR)

Default:

In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

By signing below, I understand that I am financially responsible for all charges whether or not my insurance covers them. I hereby assign my insurance benefits to be paid to Robert L. Rodriguez, DDS and its assignees. I also authorize the doctor to release to my insurance carrier(s), any information required to process any claim.

Patient's Name: _____

Signature of Responsible Party: _____ Date: _____

ROBERT L. RODRIGUEZ, DDS
DENTISTRY WITH A SMILE

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