# Financial Contract

## *Patient:*

Name: Mr. Mrs. Miss Dr. _____ (First) _____ (M.I.) _____ (Last) Birthdate: _____ (Month) _____ (Day) _____ (Year)

## *Insurance Provider:*

Policy Holder Name: _____ (First) _____ (Last) Birthdate: _____ (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:*

Patient initials: _____

1. Payment is due at the time when services are rendered.
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.

Patient initials: _____

5. Late payments will accrue monthly finance charges equivalent to 18% annually (18% APR).
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. This notice cannot be left on the answering machine, nor can it be given over the weekend.

Patient initials: _____

## *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: _____

Murrieta Dental Care • Todd R. Kamena, D.D.S. • www.MurrietaDentalCare.com
1042 Murrieta Boulevard, Livermore, CA 94550 • (925) 447-4800 • FAX: (925) 447-4812