FAMILY DENTISTRY OF SAN ANTONIO
7072 BANDERA RD
SAN ANTONIO TX 78238
210-684-6822

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance.
We will prepare and file you Insurance Claim for you, however, you must understand that:

- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to this contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payment, covered charges and "usual and customary" charges.
- We are contracted with certain PPO Insurance Plans, we will follow the guidelines for patient care, reimbursement and submission for claims for services rendered. Any contractual discounts will be deducted from your balance.
- All charges are your responsibility whether your Insurance Company pays or does not pay. Not all services are a covered benefit in all contracts. Some Insurance Companies arbitrarily select certain services they will not cover.
- Fees for these services, along with unpaid deductibles are due at the time of treatment. We collect the portion not expected to be paid by the Insurance Company, send all claims and wait up to a maximum of 60 days for the Insurance Company to pay on a claim from the day of treatment.

There is a service charge of 1.5% per month (18% per annual) on the unpaid balance on all accounts exceeding 60 days. In addition, should this account be forwarded to a Collection Agency, you agree to be responsible for any and all Collection Cost charged to this office related to the agency collection efforts. <u>There is a $35.00 charge for returned checks or charge card returns.</u>

I understand a fee estimate listed for dental care can only be extended for a period of 6 months from the date of examination. On PPO's the fees is set by your Insurance Company and subject to change without notice by your Insurance Company.

WE RESERVE THE RIGHT TO CHARGE A PER HOUR FEE FOR BROKEN OR MISSED APPOINTMENTS UNLESS 48 HOUR ADVANCED NOTICE IS GIVEN.
In consideration for professional services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of said services to Doctor, or his associate at the time services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me in writing, within the time for payment thereof.

( )yes ( ) no: I authorize release of information to the Insurance Company necessary the processing of dental insurance claims and further authorize payment of dental benefits directed to FAMILY DENTISTRY OF SAN ANTONIO.

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Signature Date