OFFICE POLICIES

Patients with insurance: (Please present your card so we may make a copy).

I hereby authorize Nina Madavi, D.D.S., A Professional Dental Corp. to furnish my insurance company with all information which said insurance may request concerning my proposed or completed treatments. I hereby authorize payment directly to Nina Madavi, D.D.S., A Professional Dental Corp. and I understand that I am financially responsible for all applicable charges regardless of a third party payer. Because there are so many forms of insurance coverage, it is my responsibility as the patient to be fully informed as to what is included or excluded in my policy, as well as the requirements and limitations. For example, **I will be responsible** for personally paying Nina Madavi, A Professional Dental Corp.:

- **Any deductibles and co-pays in full at the time of service**
- **Any insurance claim denial**
- **My lack of eligibility with the insurance**
- **The lack of prior authorization provided by me or my dentist**

Patients without insurance:

If you do not have insurance, payments are **due in full at the time of service.**

For your convenience, we offer the following payment options:

- CareCredit (can not be utilized with any other discounts)
- Automatic credit deduction, on 1st of the month.

All patients please note:

- There will be a $20 late fee on any late payments
- **24 hour notice is required for all cancellations. There will be a $75.00 fee for any late cancellations or no shows.**
- There will be a $25.00 charge on insufficient funds checks.

As patient or legal guardian of patient, I agree to pay any unpaid balances for all services rendered within 30 days of service in accordance with the financial policy of this office. In the event legal action should become necessary, I agree to be responsible for and pay all reasonable attorney and court fees incurred. I understand that this office bills insurance as a courtesy and that payment of the charges for these services is my responsibility.

I, _____ have read, agree and understand the office policies.

(Patient/Guardian, First & Last Name)

_____ _____

Signature Date