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## FINANCIAL POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time the services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help me prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid to an insurance company.

I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. A service charge of 1.5% per month (18% per annum)(but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, the Doctor and/or his/her staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his/her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed to me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I understand that contracts can be set up with the office to facilitate treatment plans and that I may speak with the office's financial representative if I need any alternate financial arrangements.

I grant permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

**Please feel free to ask questions that remain unanswered whether before or after treatment. We wish to be of assistance.**

I HAVE READ AND UNDERSTOOD THE ABOVE.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Account No. \_\_\_\_\_