## MISSION DENTAL ARTS

La Paz Medical/Dental Center 26302 La Paz Rd. Suite 109 Mission Viejo, CA 92691

## **Financial Agreement**

A)	I understand that if I must change an appointment I must give at le \$25 policy fee for a <i>no call, no show</i> scheduled appointment. (	
B)	Insurance estimate are estimates only and not a guarantee. Ber eligibility which I have verified. I understand and accept respons not paid within 45 days of billing service.	•
C)	I am aware that unless other specific arrangements are made beforehand, payment is due at the time of treatment. I am responsible for the entire balance and for complying with the terms of payment option I have chosen. I further understand that any balance over 45 days past due will be subject to a 1.5% per month (18% per annum) finance charge and that will I will be liable for any attorney fees incurred in collecting and delinquent balance. (Patient Initials)	
D)	I authorize Dr. Margaret D. Almajano to keep my signature on fil authorizations.	e for all insurance billings/ pre (Patient Initials)
E)	A \$25 fee will be charged to my account for any returned check.	(Patient Initials)
	Please check your payment form preference.	
0 0	Cash Check CareCredit #	
	CareCredit #  AMEX/VISA/MC/Discover #	Exp Date:
	Patient/Responsible Party	Date:
	Treatment Coordinator	Date: