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 least 24 hour notice.** There is a $25 policy fee for a ***no call, no show*** scheduled appointment. **(Patient Initials)** _____

B) **Insurance estimate are estimates only and not a guarantee**. Benefits are based on **my eligibility which I have verified**. I understand and accept responsibility for any insurance claims not paid within 45 days of billing service. **(Patient Initials)** _____

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 file for all insurance billings/ pre-authorizations. **(Patient Initials)**_____

E) A $25 fee will be charged to my account for any returned check. **(Patient Initials)**_____

Please check your payment form preference.

- o Cash
- o Check
- o CareCredit # _____
- o AMEX/VISA/MC/Discover #_____ Exp Date:_____

Patient/Responsible Party _____ Date: _____

Treatment Coordinator _____ Date: _____