Paseo Family Dental & Dentures

Darren M. Chugg, D.M.D. 6120 W. Bell Road, Suite 170 Glendale, Arizona 85308 (623) 487-1122

FINANCIAL POLICY AND CONSENT

Updated 03/07/2023

Thank you for the opportunity to help you meet your oral health goals. Insurance benefits (if applicable) have been verified to the best of our ability based on the information provided by the patient. During our discussion of your treatment recommendation, we have provided you with an *estimate* of fees and patient co-pays.

I understand that this estimate is not a guarantee of coverage/benefits or that the coverage/benefit amounts shown will remain unchanged until the date services are rendered. Any claim submitted is subject to all plan provisions including eligibility requirements, exclusions, limitations, and state mandates. Coverage will be determined on the basis of the facts existing when services are rendered. **Patient/Guardian Initials: _____**

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me.

As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a $25.00 returned check fee. For any payment that I make by credit card or by debit card to the dentist or any collection agency to which my account has been assigned, I authorize the dentist or collection agency to add to each such payment the fee or charge actually incurred by the dentist or collection agency for processing the credit card or debit card payment not to exceed $10.00 per payment.

Any account balances that remain unpaid for 90 days from the date of service shall accrue interest at the rate of 18% per year and may be referred to a collection company or an attorney. In the event this occurs, I understand that I will be liable for collection costs of $30.00. Additionally, in the event any unpaid account balance is referred to an attorney for collection by the dentist or a collection agency, I agree also to be responsible for all costs and reasonable attorneys' fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me, and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred (a) by mail at any address that I provide to the dental office and/or (b) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

I also understand that this form is the office policy and as a patient, it is in effect whether this form is signed or not. These such terms may be amended by the practice at any time, and an updated policy will be provided to me.

Patient Signature: _____ Date: _____

Print Patient Name: _____

Guardian/Responsible Party Signature, if minor: _____ Date: _____

Print Guardian/Responsible Party Name: _____