# OFFICE POLICIES

$25 fee will be assessed on missed appointments with less than 24 hour notice. Notice is appreciated so we may be able to serve other patient's needs.

I understand and acknowledge that I am financially responsible for the services provided for myself or the below named individual, regardless of insurance coverage on the day services are rendered.
All fees are due and payable at the time of your appointment. For your convenience, we accept cash, check, MasterCard, visa, American express and discover.

As a courtesy, we accept assignment of insurance benefits, allowing you to pay your deductible and/or estimated co-payment at the time of treatment.

I understand that my insurance policy is a contract between my insurance provider and my self, not between the insurance company and Dr. Perez.

I also understand that insurance policies vary greatly from one policy to the next and that Dr. Perez and her staff are not responsible for knowing all the details of my policy.

We have no control over insurance company's payment of claims. Any balance left unpaid by your insurance company 60 days after service is due in full by you.

I understand that Dr. Perez's office staff is authorized by Dr. Perez to file my insurance as a courtesy to me.

Our office always maintains quality sterilization procedures for your protection and safety as well as safeguarding our staff.

We reserve the right to assess fees for: Returned Checks ($25), Duplication of records ($12-20), outstanding collections (4%).

We provide services on an appointment basis. While we make every effort to be punctual, there will be emergencies or circumstances beyond our control that may delay our appointment schedule. Only one dentist is present to serve your dental needs. Your patience is appreciated.

Please notify the office staff if you have any special needs when you arrive.

I give my CONSENT to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending Dentist or by her supervised staff for diagnostic purposes or dental treatment.

The undersigned has read and accepts the above, and agrees to abide by all terms and conditions as stated.

PATIENT SIGNATURE____________________________Date____________________

(*If patient is a child, parent signature is needed*)