Rajneesh K. Dail, D.D.S.
Practice Limited to Pediatric Dentistry
337 El Dorado Street, Suite B-2, Monterey, CA 93940
(831) 373-2055

Financial Responsibility & Assignment of Insurance Benefits

This office is pleased to welcome your child as a new patient. To prevent any misunderstandings regarding payment for your child's treatment, please review and sign the following policy.

After the examination of your child is completed, you will be given a summary of the projected treatment along with an estimate of the anticipated fees.

Cash Patients:
Payment is due at time of service. No personal checks are accepted at the first visit and/or first treatment. Any cash balance over 60 days is subject to a finance charge of 1.50% per month.

Patients With Insurance:
No personal checks are accepted at the first treatment visit.

As a service to you and/or your family, this office will file your dental insurance benefits. However, please remember that insurance is not a guarantee of payment and is not to be considered as a total method of payment for our services. The patient/guarantor is responsible to pay any deductibles or patient estimated portions at the time of service.

If for any reason the insurance does not pay, I (the undersigned) assume full responsibility of the unpaid charges. If the insurance company does not pay benefits within **60 days** from our filing date, the guarantor will become responsible for the outstanding balance.

Fees or benefits quoted in this office are estimates only. Final charges or benefits paid by the insurance company will be based on treatment performed and claims filed after treatment has been completed.

I understand that if a check I have written for dental treatment is returned by the bank for insufficient funds, there will be a returned check fee of $30.

I understand that unpaid balances may be subject to 1.50% (APR 18.00%) monthly finance charge.

If the account becomes past due and is assigned to an attorney or collection agent, this office is entitled to all reasonable attorney's fees and/or costs of collection.

The undersigned agrees, whether signed as Agent, Guarantor, or Patient, that in consideration of the services to be rendered to the Patient, the patient hereby individually obligates himself to the pay the amount of the account to this office in full or other satisfactory financial arrangements must be made prior to time of patient services. Further, should it become necessary to enforce the collection of the account, the undersigned(s) singularly and jointly agrees to all such collection expense. All delinquent accounts bear interest charges at the highest legal rate.

I authorize release of any information necessary to determine liability for payment and to obtain reimbursement of any Insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled to Rajneesh K. Dail,D.D.S. This Assignment will remain in effect until revoked by me in writing. A photocopy of this Assignment is to be considered as validas an original.

I understand that the charges of this account remain the responsibility of the person signing this form, either: the Patient, Guarantor, Parent, Guardian or accompanying adult.

I fully agree to the Patient Financial Responsibility and Assignment of Insurance Benefits as stated above.

Patient's name_____

Signed:_____

Parent's name_____Date_____
(please print name)

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Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have a **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **48 hours** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred with out the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Dr. Dail's Appointment Cancellation Policy.

_____ _____
Signature of Patient/Guardian Date