HARISH HEGDE, D.D.S.
9111 VALLEY VIEW STREET
SUITE 106
CYPRESS, CA. 90630

IN ORDER TO PROVIDE OUR PATIENTS WITH THE BEST POSSIBLE TREATMENT AND KEEP THE COST OF THAT TREATMENT REASONABLE, WE HAVE FOUND IT NECESSARY TO REVIEW OUR FINANCIAL POLICY. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY, WHICH WE REQUIRE THAT YOU READ, AND SIGN PRIOR TO ANY TREATMENT.

A.) I understand that it is my sole responsibility, as a member of my insurance company, to be thoroughly aware of my benefits and co-pays before Initializing or completing treatment recommended by Dr. Harish Hegde D.D.S. ___________ (Initials.)

B.) I also understand that authorization for treatment is not protocol for the Dental office unless Insurance requires It or upon my request ____________ (Initials.)

C.) I understand that Dr. Harish Hegde D.D.S. Dental office is the third party in relations to my insurance company. Therefore, I am financially responsible for any charges not covered under my Insurance plan ______________ (Initials.)

D.) Credit is not extended to first time patients. Emergencies and first appointments are payable at the time of service.

E.) Patients with insurance are required to pay deductible and estimated co-payment at the time of treatment. I agree that finance charges will be applied to the outstanding balance if my insurance does not pay its estimated portion within a 90 day period _____________ (Initials.)

F.) We accept MasterCard, Visa for those patients wishing to extend payments. Financing is also available. If you are interested in financing please ask for application.

G.) For any procedure involving laboratory services, ½ down is required when treatment is started, ½ due upon completion (Crowns/Bridges or any other type of major work.)

H.) Payment-plans are available for special circumstances. Post-dated checks are accepted, but must be arranged prior to treatment (not available to first time patients). The maximum extension is three months (finance charges included).

I.) If your payments are not received by the due date, you will be assessed a late payment charge. The late charge will be $5.00 or 5% of the past due amount, whichever is greater unless other arrangements have been made with our office.

J.) We offer a 10% Senior Citizen discount.

K.) An additional charge of 35% will be added to your account in the event the account has to be assigned to an external collection agency.

L.) There will be a $25.00 charge for all returned checks.

M.) HMO patients receive a discounted co-payment; therefore payment is due at the time of service.

Once an appointment time has been reserved for you. We ask that a minimum of 24 hrs notices be given if you are unable to keep the appointment. This courtesy on your part will make it possible to schedule another patient waiting for treatment. Please note that there may be a service fee of $20.00 for broken appointments without a minimum requested notice given __________ (Initials.)

I, ________________________________ (PRINT NAME) have read, understand and agree to the above policy. I understand that I am fully responsible for the fees of services rendered, regardless of any insurance that I may have. I agree to pay all costs and expenses incurred should my account be turned over to a collection agency, including any attorney fees.

________________________________ ________________

Patient or (guardian) Date