Sherman Oaks Dentistry
Dr. Harold Perlaza D.D.S.
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Financial Policy

We appreciate the opportunity to serve you! We've found that a clear understanding of our financial policy in advance of dental care helps to relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you might have. We will do our best to answer them for you.

Patients without insurance coverage need to know . . .

Full Payment is due at the time of scheduling in order to reserve an appointment. The fee for the treatment rendered must be paid in full on the day of service. Our practice is committed to providing the best treatment for our patients and we charge what the usual and customary fees are for our area.

Patients with insurance coverage need to know . . .

Full payment is due at the time of scheduling in order to reserve an appointment.

The estimated patient co-pay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that you are ultimately responsible for all fees generated by your treatment.

We accept Visa, MasterCard, American Express, Care Credit, checks, and cash for payment of the amount due. Payment plans are available. Please ask about them if you need one.

Three business days notice is required for rescheduling appointments.
A $75 to $150 fee, depending on the amount of time that was reserved for you, will be applied to your account for rescheduling, canceling or failing to show up for your appointment without 3 business days notice. If you are more than 15 minutes late for your cleaning reservation, you will either take the remaining time only or reschedule **and** pay a broken appointment fee of $75. Dr. Perlaza and Cynthia reserves your appointment time exclusively for you; they do not "double-book" and keep extra patients waiting in case you can't come. Please be considerate.

Treatment Plans: You understand that if Dr. Harold Perlaza has treatment recommendations for you, you will receive an itemized list of the recommended treatment. This will also contain an estimate of what the fees will be for the recommended treatment. If you have dental insurance, the treatment plan may include an

additional estimate calculating what may be paid by your insurance company toward the fees for your treatment. You understand that treatment plan ***estimates are not a guarantee*** of insurance payment and you are ultimately responsible for all fees generated by your treatment.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when a statement is issued, and is overdue if not paid by twenty-one (21) days after the statement date.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees that we incur plus all court costs. In case of suit, you agree the venue shall be in Ventura County, California.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, or if we have to litigate in court. Or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned checks: There is a fee (currently $35) for any checks returned by the bank. That you will be responsible to pay.

Insurance Release: You authorize Dr. Harold Perlaza to release any necessary information requested by your insurance carrier and authorize payment directly to Dr. Harold Perlaza for any benefits available under your insurance plan.

Insurance: Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. Please note that services are not rendered on the assumption that the insurance company will pay us. You are ultimately responsible for payment of all fees generated by your treatment. If your insurance company has not paid your claim within ninety (90) days after the date of service, the full amount is due and payable by you. We will promptly refund to you any insurance payments we receive if you have already paid the balance on your account. It is your responsibility to inform us of any changes in your insurance coverage.

Transferring of Records: You may request with a signed consent, if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Minors: The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charged have been pre-authorized before the appointment date or previous arrangements have been made with the finical secretary.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing department promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Finical Policy.

_____ _____

Print Name Date

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Signature