Silicon Valley Center For Cosmetic Dentistry
Gabriel Cano, D.D.S.
Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to provide you with the highest standard of dental treatment.
The following is a statement of our financial policy, which we require that you read and sign, prior to any treatment. All patients must complete our patient history and financial policy form before seeing the doctor.

Payment in full is due at the time of service. We accept cash, check, Visa and Master Card. We also offer extended payment plans with prior payment approval with *Dental Fee Plan*.

REGARDING INSURANCE

For those patients covered by insurance, we are happy to extend the courtesy of billing your insurance company for you, provided we are supplied with all of the necessary information to do so. We do, however, require payment of your ***estimated*** portion at the time of service. Please know that this is nearly an estimate, based on the information we get from your insurance company over the telephone, Internet or fax. They do not guarantee any information they provide us and final determination is done when they process your dental claim.

If your insurance does not make payment within thirty days, you will be expected to investigate this claim and clear any balance with our office. Your insurance policy is contract between you and your insurance company. We are not a party to that contract and therefore do not pursue any claims not paid by your carrier. Please remember, by providing full and accurate information regarding your insurance carrier, you facilitate successful processing of your claim.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for payment of our appropriate fee regardless of any insurance company's arbitrary determination of usual and customary rates.

PAST DUE ACCOUNTS

We assign all accounts over ninety days to a collection agency for processing.

CANCELLATION POLICY

Your appointment time is reserved for you and a fee will be applied for canceling or failing an appointment ***within 48 hours notice***. Appointments are to be rescheduled during regular business hours. Please understand that our *answering service is available for emergencies only and does not make or cancel appointments.*

FOR ALL PATIENTS

I hereby authorize the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I also authorize the doctor to prescribe any and all forms of medication and perform any therapy that may be indicated and agreed upon. I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the doctor to make any/all changes and additions as necessary. I agree to pay for all services rendered by this office.

HIPPA

I read and received a copy of the HIPPA Notice of Privacy Practice.

______________________________ Name

______________________________ Date

REGISTRATION AND HISTORY

PATIENT INFORMATION

Date____________ Patient Name____
Last First

Address____
City___________________________________ State______ Zip________________
Email____
Sex ☐ M ☐ F Age____________________
Birthdate____
Employer____________________________________ Occupation________________
Is patient a student? ☐ Y ☐ N Full time student ☐Y ☐N Part time student ☐Y ☐ N
School Name________________________ Address: _________________________
Spouse's Name____
Birthdate_____________________________ SSN_____________________________
Spouse's Employer______________________________ Occupation______________
Whom may we thank for referring you?___________________________________

PHONE NUMBERS

Home: ______________________________ Work:_____________________________
Cell: _______________________________ Spouses Work:_______________________

In case of emergency, contact: ________________________ ***Phone:*** ___________________

DENTAL INSURANCE INFORMATION

Who is responsible for this account?______________________________________
Relationship to Patient____
Insurance Co._________________________________Group #___________________
Is patient covered by another insurance?______________ Subscriber's Name:___________
Birthdate_________________________ SSN___________________________________
Relationship to patient_____________________________ Insurance co_______________
Group #____

ASSISGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________
Name of Insurance Company(ies)

And assign directly to Dr. ______________________________all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above – name dentist may use my healthcare information and may disclose such information to the above – name insurance company(ies) and there agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

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Signature of patient, parent, or guardian

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Please print name of patient or guardian

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Date Relationship to patient