davila velazquez

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security no:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone no.: ( )	Cell Phone no.: ( )

City:	State:	Zip Code:	Email Address:

Occupation:	Employer:	Employer phone no.: ( )

Whom may we thank for referring you?: ❑Friend_____ ❑Dr._____ ❑ Insurance Plan

❑ Family ❑ Online ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance Company Name:	Insurance Company Address:	Insurance Co. Phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. **Payment is due in full at the time of treatment** unless prior arrangements have been approved. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize my insurance benefits be paid directly to Drs. Davila & Velazquez, P.A.. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Patient/Guardian signature *Date*

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Financial Policy:

Payment is due in full at the time of treatment. We accept the following forms of payment: cash, checks, Visa, MasterCard, Discover, & American Express. We have no interest payment plans available through **Care Credit®**. Our office will gladly assist you with your application process. When major dental work is needed (crowns, bridges, dentures, orthodontic appliances, etc.) a **50% deposit** will be required when the treatment is started. The remaining balance is due at the time the appliance is delivered. Checks that are returned for insufficient funds are subject to a **$35 returned check fee**. This fee covers the processing fees that are charged to our office.
Once the insurance payment has been received any deductibles or procedures not covered by insurance will be the responsibility of the patient and payment is due within 45 days. If a patient's account is not paid within 45 days, the account will be placed with a collection agency or sent to an attorney. Delinquent accounts are subject to a **$5.00 monthly service charge**. In the event an account is turned over to a collection agency or attorney, the patient or person responsible for the patient's account agrees *to pay collection, court costs and any other reasonable costs for collection*. For billing and payment inquiries or to apply for payment arrangements, please contact our business office at 252-756-7789. All final settlements regarding accounts must be discussed with one of the officers of the corporation.

Cancellation Policy:

Our primary goal is to assist you in attaining and maintain optimal oral health. Therefore, your appointment time is reserved exclusively for you. We trust that no change in your appointment will be necessary and we will call you 48 hours in advance to confirm your reserved time. You will be asked to give our office 2 business days notice should you need to cancel your reserved appointment. This courtesy on your part will make it possible to give your appointment time to another patient. If you fail to keep an appointment, *or give less than 24 hours notice* for a cancelation, there will be a **$50.00 charge.** We reserve the right to dismiss you from the practice if you fail to show for two or more appointments.

Dental Insurance Policy

Your Dental Insurance Policy is a contract between you and your insurance company. We are not part of that contract.
We do accept assignment (payment) of benefits from most insurance companies. Please provide us with your dental insurance information BEFORE your appointment, and as a courtesy we will file your insurance claim for you at no charge. If you are not the policyholder, make sure that you have all the policyholders' information in order to file the dental claim.
If your insurance company has not paid your account in full within 45 days, the balance will be transferred to your account. Please be aware that some of the services provided may be non-covered services and/or not considered reasonable and customary under the terms of your insurance policy. An insurance company surveys a geographic area, calculates an average fee and then takes that fee and considers it customary. Included in this survey are discount clinics and managed care facilities which provide services to the medically indigent patients, bringing down the average "customary fees" for that area. Most doctors in private practice will have fees, which are defined as "above usual and customary" under your insurance parameters. **Our practice is committed to providing the best treatment for our patients and our fees are a true and accurate representation of the skills, the quality, and the expertise involved in all the services provided.** You are responsible for payment regardless of any insurance company's determination of usual and customary rates. If you do not agree with any decision made by your insurance company is your right and responsibility to appeal. We will gladly provide you with the information needed and will offer help with the appealing process.
We cannot guarantee insurance coverage payments or benefits. At times your employer changes from one insurance company to another or your current insurance company may require you to update certain information. We are **NOT** responsible for updating your information with your insurance company or investigate who is your new insurance carrier.

I, _____, have read and understand the above policies.

_____(Patient's signature) _____(Date)