

13223-4 Black Mountain Road
San Diego, California 92129
858 484-9222

PQ Family Dental

1668 Main St. Suite B1
Ramona, California 92065
760 789-6200

FINANCIAL POLICY

PAYMENT OPTIONS

In order to facilitate access to the very best health care possible, and to have those services comfortably affordable, we are pleased to offer you these options for payment:

*VISA, Mastercard, American Express, Discover

*If you have no insurance, we offer a 5% discount when all fees are paid at the time of service.

*Dental Fee Plan – we offer outside financing to help you with affordable monthly payments.

Initial _____

UNDERSTANDING INSURANCE

Please be aware that your insurance contract is between you and your insurance company and we are not a party to this agreement. We do our best to understand your dental benefits but we can not be responsible for all details pertaining to every insurance plan. It is your responsibility to know your insurance limitations and to pay for all services, regardless of what your insurance ultimately pays.

Initial _____

INSURANCE ESTIMATES

We do our best to give you accurate estimates as to what your insurance will cover on procedures performed in our office. Please be aware that any insurance estimates given you in our office are **only** estimates. We have very little control over your insurance companies payments for services rendered.

Initial _____

USUAL AND CUSTOMARY RATES

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

Initial _____

MINOR PATIENTS

This office is **not** a party to divorce decrees. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

Initial _____

I AGREE THAT I AM FULLY RESPONSIBLE FOR THE TOTAL PAYMENT OF ALL PROCEDURES PERFORMED IN THIS OFFICE – THIS INCLUDES ANY TREATMENT THAT IS NOT A BENEFIT OF ANY DENTAL INSURANCE THAT I MAY HAVE.

Signature (Patient or Legal Guardian)

Date