San Angelo Smiles
Max Teja, DDS

Office Policies and Payment Conditions

Payment is due at the time of service. We accept cash, checks, and major credit cards. We offer outside financing options known as Care Credit or First Financial Bank. A Payment Plan may be utilized in accordance with Office Policies.

Insurance

This office will prepare insurance claims and assist in collecting from your insurance company. All money paid to the office will be credited to the patients account. In the event of an insurance over-payment or the insurance requests to be refunded, we will refund the insurance company. In the event your insurance does requests a refund, the patients account will be charged. This office cannot render services under the assumption that our charges will be paid by an insurance company. Patients who carry dental insurance must understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for all charges incurred, even in the event the procedure or procedures are deemed by your insurance as a non-covered procedure. If the Insurance Company sends payment directly to the patient, the patient is responsible for payment of all services. This office and its Clinical Team follow the "Standard of Care" set by the State Board of Dental Examiners to assure you the best care possible. At the time of service, our office will estimate your portion based on benefit information given prior to your visit. You will be expected to pay the estimated portion at the time services are rendered. This portion is only an estimate. A statement will be sent every month to keep you aware of your account. **After 90 days, you will be responsible for any remaining balance**.

Office Policies

All emergency dental services, or any dental services performed without previous financial arrangements must be paid in cash at time of services.

We respect your concern for your loved ones but due to the delicacy of our equipment and other patient privacies we request only the patient be present in the operatory. Additional family members must wait in our reception area.

We value your time and hope you will value ours. **Our office reserves the right to charge for broken appointments in the amount of $25.00 without a 24 hour notice.**

Authorizations

I do hereby authorize Laser & Cosmetic Dentistry or Dr. Max Teja to release all information necessary to secure the payment of benefits. I authorize the use of this signature on file for all insurance claim submission whether manual or electronic, (please initial____________).

I hereby authorize payment directly to Max Teja D.D.S. of the group insurance benefits otherwise payable to me, (please initial____________).

I do hereby authorize dental services for my child including, but not limited to, X-rays, treatment and administration of anesthetics deemed necessary or advisable by the Doctor, whether or not I am present at the appointment when treatment is rendered (if applicable, please initial ___________).

I have read the above office policies and payment conditions and agree to their content. My signature below represents my agreement.

Signature: ____ Date: _______________________________

(Signature of patient, parent/guardian)