



PABLO E. SOTELO D.M.D.  
fellow of academy of general dentistry

### OFFICE FINANCIAL POLICY

We are committed to providing you with the best possible dental care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

If we do not have a contractual agreement with your insurance company, payment for office services is due at the time services are rendered. We accept cash, checks and major credit card payments. We will be happy to help you process your insurance claim for reimbursement. An insurance claim form, when indicated by your insurance company, must accompany any such request.

Returned checks are subject to applicable bank fees of not less than \$25.00. A delinquent billing charge of \$25.00 plus interest at the rate of 1.5% per month will be assessed to all account balances over 30 days.

We will gladly discuss your proposed treatment and answer any questions related to your insurance.

You **MUST** realize, however, that:

1. **ALL CO-PAYMENTS ARE TO BE MADE AT TIME OF SERVICE.**
2. If you have an indemnity plan, your insurance is a contract between you, your employer and the insurance company.
3. Our fees are generally considered to fall within the acceptable range by *most insurance companies* and, therefore, are covered up to the maximum allowance determined by each carrier. Thus, our fees are considered to be usual and customary by most companies.
4. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
5. You are responsible for informing us of any changes in your insurance plan or policy. Failure to do so may result in denial of coverage, the fees for which you will be held responsible.
6. Deductibles, co-insurance and co-pays are the **RESPONSIBILITY** of the patient/policy holder.

If you do not have the proper forms described in your insurance handbook, you **MUST** reschedule or, if your plan offers "Out of Network" benefits, you may be seen as an "Out of Network" patient at a somewhat higher cost to you.

**WE MUST EMPHASIZE THAT, AS DENTAL CARE PROVIDERS, WE ARE DEDICATED TO PROVIDING THE BEST TREATMENT TO OUR PATIENTS. WE WILL DO OUR BEST IN THE FILING OF INSURANCE CLAIMS; HOWEVER, ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.**

Thank you for your understanding of our Office Financial Policy. If you have any questions, please do not hesitate to ask.

I have read the Office Financial Policy of Frankford Dental Care. I understand and agree to this policy and have had all of my questions answered.

\_\_\_\_\_  
Signature of Patient (Guardian)

\_\_\_\_\_  
Date