ADVANCED
MICRO-ENDODONTICS, INC
MICROSCOPE-BASED ENDODONTICS

PATIENT FINANCIAL POLICY

PATIENTS WITH DENTAL INSURANCE: As part of our service to you, our office gladly processes your dental insurance claims, any insurance deductible and/or **estimated** co-payment is due at the time services are rendered.

I authorize and hereby request my insurance company to pay dental benefits directly to Dr. Nazeri. I understand that my dental insurance plan may pay less than the actual amount billed for dental services. I agree to be responsible for payment of ***all*** services rendered on my behalf or on the behalf of my dependents. I understand that all insurance co-payments are due at the time treatment is performed.

Patient Initials: _____

Payment Methods: Cash, Visa, MasterCard, American Express, Discover and Care Credit. We do not accept personal checks.

Outside Financing is Available: Ask about the Care Credit Card.

Overdue Balance: A finance charge of 5% will be charged to all accounts monthly with an overdue balance.

Missed Appointments: We require 48 hours notice from you to cancel an appointment (if the appointment is on Monday, you must cancel by Friday at noon). If you have missed an appointment without giving our office the appropriate notice, your account will be charged a $100 missed appointment fee.

For Non-Insured Patients: Payment is due in full at each treatment session.

I UNDERSTAND AND ACKNOWEDLGE THE ABOVE FINANCIAL POLICY.

X _____ **Date:** _____

Signature of patient