BAY DENTAL
AT THE POINTE

Patient Financial Responsibility

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our policy, or your financial responsibility. By signing below you agree to be financially responsible for any and all medical and or dental services provided.

If you have dental insurance, please provide is with a current copy of the card. You are responsible for payment of any co-pay, deductible, or co-insurance amount or non-covered services.
Payment is expected at the time of the visit/service. We accept cash, checks and credit cards.

Initial here_____

Service charges:
Return check fee: $30
Accounts referred to collections will be charged $50 or 25% of the balance, whichever is greater. ** 48 hours notice is required for schedule changes. All appointments rescheduled or "no show" after this time will be charged for Doctor's or the Hygienist time. The charge will be $50 per scheduled hour. A courtesy call will be given prior to appointments, however, please do not rely solely on this call. At times, phone lines are busy, machines are not left on or tape is full, or patients are hard to get a hold of. It is the patient's responsibility to know when they have scheduled their time with us. Helping us keep your appointments and being on time will in turn help you.

The undersigned patient hereby authorizes this practice to submit Insurance Carrier Claim Forms on behalf of the patient without further signature authorization. This form also authorizes Bay Dental At The Pointe, P.C. to receive payment directly from the Insurance Carrier. All claim forms will be submitted to the notation "Signature on File". **I understand that although I have given insurance information, insurance is not a guarantee of benefits and I am responsible for my bill and any unpaid insurance claims**. I certify that the information given above is true and correct to the best of my knowledge.
If your insurance company does not accept assignment of benefits (they mail the check directly to you in that case) then you are responsible to pay for the services as they are rendered, Bay Dental At The Pointe, P.C will file your claim and you will then be reimbursed by your insurance carrier directly.

By signing below I authorize Bay Dental At The Pointe, P.C. to have a copy of my driver license and additional identification on file. To the extent permitted under applicable law, I authorize release of any information relating to the claim, including the diagnosis and records of any treatment or examination rendered to me or my dependents to third party payers and/or health practitioners.

I authorize Bay Dental At The Pointe, P.C. to initiate a complaint to the Insurance Commissioner for any reason on my behalf, I also authorize any pre and post op photos of my dental treatment to be used for any marketing and/or educational purposes. If my photos are chosen my identity will be concealed with my eyes being masked out of photos.

The undersigned patient hereby agrees to the payment and cancellation policy stated above. A photocopy of this document may act as the original.

Signature _____ Date: _____

Guardian signature (if minor)_____ Date: _____