AUTORIZATIONS & AGREEMENTS

Please choose one of the following options below:

☐ I have dental insurance

☐ I have no dental insurance

Financial Agreement /Guarantee of Payment

In consideration of services and care rendered for today's visit and all future visits, I agree that I am responsible for any and all changes billed by La Jolla Cosmetic and Family Dentistry and I understand that all payments are due on the day the service is rendered. The fees that I am quoted remain in effect for 6 months or until the plan raises it's fees. If I have dental insurance and my insurance plan is one of the plans with which La Jolla Cosmetic and Family Dentistry participates, I understand that La Jolla Cosmetic and Family Dentistry will bill my insurance carrier directly and will accept assignment on covered services but I agree to pay co pays. Upon receipt of a La Jolla Cosmetic and Family Dentistry bill, I agree to pay all amounts not covered by insurance immediately.

If I make a change to my insurance coverage, I understand that it is my responsibility to notify La Jolla Cosmetic and Family Dentistry.

I understand there is a fee of $25 for returned checks.

Release of Information for Payment of Claims

I authorize La Jolla Cosmetic and Family Dentistry to release any and all information needed exclusively for the payment of professional charges and to permit representatives of those Responsible for such payment the examination and copy of al records relating to the care and treatment received, if requested.

Appointment Policy/No – Show Fee

I understand that La Jolla Cosmetic and Family Dentistry reserves the right to charge a "No Show Fee" of $25 for missed appointments and for appointments that are cancelled with less than 24 hour notice.

☐ Yes. I have read, understand and agree with the above Policy of La Jolla Cosmetic and Family Dentistry.

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Signature of Patient or Authorized Representative Date