MORA
FAMILY DENTISTRY

Lauro Mora Jr. D.D.S.
Elizabeth Mora D.D.S.
Laurel Mora Santos D.D.S.
Lauro Mora III D.D.S.

1402 Pennsylvania Ave. Fairfield, CA 94533
Phone: (707) 425-6216
Fax: (707) 425-6241
Email: info@moradentistry.com
Website: www.moradentistry.com

FINANCIAL POLICY

We feel that everyone benefits when there is a definite and clear understanding of our financial policy prior to treatment.

1. *Payment is due at the time of service*: An estimate of your total fee will be outlined in detail with you at the time of your initial visit.

2. *Patients with insurance*: As a courtesy, our office will file your insurance if you provide us with the proper information. You are expected to pay your deductible and any out-of-pocket portions at the time services are rendered. Payments from your insurance company are expected to be remitted directly to the doctor for the service rendered to you or your dependent(s). In the event that an insurance payment is insufficient to cover the entire expense or the treatment is not covered by your policy, you will be responsible for the difference or the entire bill. However, if your insurance pays more than the estimated amount, we will refund you promptly. If your insurance company does not make a payment within 60 days, you will be notified. If payment is not received within 90 days, you are immediately responsible for the remaining balance.

3. *Finance Charge*: If an account, which is the patient's responsibility, is not paid in full within 30 days, a 1.5% service charge will be added to the account balance per month.

4. *Missed Appointment Fee:* We would appreciate your consideration in giving us at least 48 hours notice should you need to reschedule. If you do not show up to an appointment you made, or cancel with less than 48 hours notice, the appropriate fees are as follows: $50 – fee for scheduled cleaning or 30 min work, $100 – fee for scheduled major work/ or 1+ hr work.

5. *Returned/Bounced Checks*: A $50 fee for Non-Sufficient Funds will be charged for returned checks. Accounts that are unpaid over 120 days will be sent to collections, and you will be responsible for any additional charges from the collection agency

For your convenience, we accept cash, personal checks, Care Credit and most major credit cards.

I grant my permission to you and your assigns, to telephone me at home or at work to discuss account matters.

I have read and agree to the above Financial Policy.

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Patient Name [PRINT] **Patient Signature**

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Date