

Elaine S. Martinez, D.M.D., P.A.  
Jila J. Mahajan, D.D.S.  
1530 Business Center Dr. Ste. #1  
Orange Park, FL 32003

## Financial Policy

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

We are committed to providing our patients with a quality dental experience. We are eager to answer any questions you may have regarding your child's treatment needs, as well as questions regarding our fees and/or your dental insurance coverage.

**Please read this policy, initial each section and sign at the bottom acknowledging you understand and agree to the terms.**

\_\_\_\_\_ Dental insurance is a contract between you, your employer and your insurance carrier. **We are NOT a part of that contract. AS A COURTESY TO OUR PATIENTS**, we accept assignment of benefits directly from your insurance company for their covered percentage of each procedure. Dr. Martinez and Dr. Mahajan are not Preferred PPO Providers for any insurance company except **United Concordia and Delta Dental DPO/PPO**. Most insurance companies pay the out-of-network-providers their "usual and customary allowable fees". **Our practice is a "specialty" pediatric dental office and our fees do not match their usual and customary fees. Therefore, you are responsible for the difference not covered.**

\_\_\_\_\_ At each visit we will **estimate** the portion that your insurance may cover. **At the time the service is provided, you will be responsible for the balance not covered by insurance. You will also be responsible for any additional balance left after the insurance company pays.**

\_\_\_\_\_ If we do not receive payment from your insurance company within 35 days of the submission date, **you will be expected to pay in full for all dental services rendered.** We will assist you in every possible way to clarify the terms of your insurance coverage.

\_\_\_\_\_ We **DO NOT** file for secondary insurance, although we will provide the necessary information for you to do so.

\_\_\_\_\_ **If no insurance coverage, payment is due and payable in full at the time the service is rendered.** We accept cash, Visa, MasterCard, debit cards, and checks (RETURNED CHECK FEE IS \$40.00). If additional visits are required in your treatment plan, our options are: payment in full on your initial visit, payment per visit as each stage of treatment is completed, or we have finance companies that we use who can arrange financing.

\_\_\_\_\_ Balances over sixty (60) days are subject to collection fees, which are 40% of the total balance.

\_\_\_\_\_  
**Signature of parent/guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**