



SPECIALIZING IN IMPLANT, AESTHETIC AND RESTORATIVE DENTISTRY

OFFICE POLICIES AND FINANCIAL ARRANGEMENTS

Welcome to Dr. Daniel F. Galindo's specialty practice in prosthodontics. We hope this information will answer some of your questions about our office's policies and financial arrangements. These are a very important part of your treatment. We require you to read and sign this document prior to any dental treatment is started.

Financial Arrangements

It is our policy to completely examine and discuss treatment plans with all patients or guardians before dental treatment is started. A complete estimate of fees and method of payment will be discussed after your initial clinical exam during the treatment plan conference. As a result of the amount of time that we invest in your treatment, along with material and overhead costs, full payment is expected at each appointment, in the form of cash, check, credit (MasterCard, Visa, American Express and Discover) or debit card. It is our policy to receive one half of the quoted fee in advance of treatment. The second and final payment is required prior to the placement of the final restorations. Interest charges (18% per annum) are placed on the account if payment is sixty days past due.

Dental Insurance

As a courtesy to our patients, we will be happy to complete and forward insurance forms relative to dental treatment, and we will do so without charge. However, in order to avoid misunderstandings, please read carefully and understand the following policies in regard to dental insurance benefits. Our professional treatment is rendered to you, not the insurance company; you are directly responsible to us for the obligation of payment of treatment. Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer. Our office is not responsible for the accuracy of co-payments, deductibles or other insurance benefits. We will do our best to see that you receive your full benefits within the structure of your particular dental plan. However, ultimate responsibility for payment is yours and your financial arrangements must be defined before dental treatment can begin.

Case Presentation and Treatment Planning Session

About 2 weeks after your New Patient Appointment, you will be scheduled for a Case Presentation and Treatment Planning Session. In the time between your initial and second appointments, Dr. Galindo will diagnose and treatment plan your case. Dr. Galindo's goal is to offer at least two treatment alternatives, whenever possible. At the CPTP Session, Dr. Galindo



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will present his clinical findings and treatment options, along with benefits and risks of each option. The fee for this session is \$195.00 and payment is expected after this appointment. If you choose to proceed with treatment in our office, this amount will be credited back to you account.

Appointment Policy

The complex nature of your dental treatment requires a series of appointments with explicit amounts of time periods between them to allow us to complete your treatment to the high standards that we constantly strive to achieve. Once your appointment schedule is determined, it is then coordinated with the dental laboratory in order to achieve a smooth progression of your treatment. If you constantly change the dates of your appointments, this affects the laboratory schedule of your treatment, and in this event we may not be able to complete your treatment on a specific date.

Should you need to change a scheduled appointment, we would appreciate the courtesy of being informed at least 48 hours in advance. If your appointment is for a half or full day, we request at least 3 working days notice. There will be an \$85 charge for failed appointments. All cancellation fees must be paid prior to scheduling another appointment.

Agreement

I accept full financial responsibility for the services rendered to me at Daniel F. Galindo, D.D.S., P.C. and understand that I am responsible for my dental cost, regardless of any insurance coverage. I have read, understood and agreed to the office policies and financial arrangements above.

Date

Print Name

Signature of Patient