Darryl K. Ragland, DDS

IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED. We accept:

- Cash Credit Card Personal Check (Please note a Service fee of up to 50% of the amount of any check returned by the bank unpaid.)

To keep the cost of dentistry as low as possible, appointments are scheduled to best fit the patient's and the doctor's time. **48-hour notice** is required to break or reschedule an appointment. **There will be a charge of up to 50% of the appointment fee for any missed or rescheduled appointments with less than 48 hours notice**

We reserve the right to refuse service/treatment to anyone according to the laws of the State of California.

FOR OUR INSURANCE PATIENTS

ALL INSURANCE CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF TREATMENT.

As a courtesy to our patients, we submit billing to most insurance companies. However, we can make no guarantee of coverage; and **all fees are patient responsibility**. Our office will do everything possible to see that you receive the full benefits of your policy. If insurance has not paid within 45 days of services rendered, the balance will be automatically due and payable. It is the responsibility of patients to know their insurance benefits. **Darryl K. Ragland accepts NO RESPONSIBILITY for benefits denied by insurance companies**. To assist our patients, our treatment plans include an estimated insurance benefit. **These are estimates only** and should not be considered a guarantee of insurance payment. **It is the patient's responsibility to provide this office with ACCURATE insurance information.**

Our practice is committed to providing the best treatment for our patients. Please be aware that some of the services provided may be **non-covered services** or not considered reasonable and necessary under individual insurance policies. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. A finance charge of 22% per annum will be charged on all balances over 60 days. A fee of $125. will be assessed if a delinquent account is referred to a collection agency

Please let us know if you have any questions regarding our financial policy.

AUTHORIZATION FOR SIGNATURE ON FILE

Release of Information/Financial Responsibility

I hereby authorize the office of Darryl K. Ragland, DDS to release all information, medical/dental and business (SS#, etc) as necessary for reimbursement of services from insurance companies and/or for the purpose of referral to a specialist for additional treatment. I understand that I can deny the transmission of such information. I further understand that should I deny permission for the transmission of information, Darryl K. Ragland, DDS is not responsible for submitting insurance billings on my behalf. _____ (initial here)

I have been offered a copy of the Dental Board of California Fact Sheet on Dental materials as mandated by California State Law and Notice of Privacy Practices mandated by HIPAA _____(initial here)

I consent to the use of before and after photos to be used for the purpose of in-house marketing. I understand these photos will not bear my name nor be posted on the internet. _____ (initial here)

I understand I am responsible for all fees charged in connection with my dental treatment or the treatment of my dependants. I understand that Darryl K. Ragland, DDS or his associates is not responsible for any fees not paid by my dental benefit carrier. I further understand that Darryl K. Ragland, DDS or his associates is not responsible for obtaining benefit information on my behalf. _____ (initial here)

I have read, understand and agree to the terms and conditions of this document and allow this document to serve as authorization for "signature on file" for the purpose of billing.

A photocopy of this document may act as an original.

_____ _____

Signature of Insured Signature of Patient or Guardian

Today's Date: _____