Periodontal Associates

Shayna S. Rondon, DDS MS

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www.perioassoc.com Tel: 925 449 6633 Fax: 925 449 0766

Financial Policy Acknowledgment

Print Patient's Name ____ DOB ____/____/______

Payment Obligations

I hereby assign, Periodontal Associates all payments for dental/periodontal services rendered to myself or my dependents until revoked in writing. I understand that I am responsible for any amount not covered by my insurance at the time of service included co-pays, deductibles, non-covered services or administrative fees (e.g. late cancel, no show, return checks, collection fees). I also understand that if I do not fulfill my payment obligation to Periodontal Associates, my account will be subject to a full collection process. Any expenses related to the cost of collection and/or legal will by my responsibility. I acknowledge I have read and I have a copy of the practice's Financial Policy. There is a copy posted on the company website www.perioassoc.com

Fees for No Show Visits or Late Cancellations:

Cancellation of office visit less than 24 hours business day prior to the appointment	$25.00
Cancellation of surgical procedure less than 24 hours business day prior to the appointment	$100.00
Administrative Fee (for past due account over 90 days sent to Collection)	$25.00
No Show for scheduled office visits	$40.00
No show for a scheduled surgical procedure	$150.00
Returned Checks (amount added to amount of check)	$25.00

Patient's Signature ____ Date _______________

Staff's Signature ____ Date _______________