DAVID B. MERGERIAN, D.D.S., P.A.
FINANCIAL POLICIES

PAYMENT:

Fees for service are due at the time of service except where financial arrangements have been previously made and agreed upon in writing. We will be happy to prepare an estimate for the cost of your care before any major care is begun. We accept cash, check, and major credit cards (Visa, Master Card, and Discover). We also offer outside financing when appropriate. When dental procedures are pre-determined to be covered by the patient's insurance, co-payment is due at the time of service. In situations where the insurance company pays the patient directly, fees for service are collected at the time of service.

DENTAL INSURANCE:

We bill your insurance company as a courtesy. If insurance does not pay within 30 days, we request payment in full from you and you are responsible to collect the insurance funds due you. This is rare, but it is important that you recognize the insurance you have is a legal contract between you and your insurance company. Our office is not, and cannot be, a part of the legal contract. Ultimately, you are responsible for all charges incurred in our office. If I do not have dental insurance, or dental insurance accepted by this office, I will be considered a self paying patient and payment is due at time of service.

AUTHORIZATION:

I authorize the office of David B. Mergerian, D.D.S. to submit a claim to my dental insurance for payment. I understand I am financially responsible for any charges not covered by my insurance.

SERVICE CHARGE:

Any balance over 30 days will incur a service charge. The service charge will be a periodic rate of 1 ½% per month which is an annual percentage rate of 18% applied to the last month's balance.

In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. As the account holder, I acknowledge, I am responsible for all dependents on the account.

Signature of patient or guardian: _____

Date: _____