**Dr. Phillip S. Zeip, D.D.S.**

**3315 Mission Dr. Santa Cruz, CA 95065**

**FINANCIAL AND APPOINTMENT CONSENT FORM**

We welcome you and your family to our office. We ask that you review and complete our office and financial policy consent form to provide you with most beneficial and comprehensive services and care. We will gladly discuss your treatment plan, financial options and any other questions you may have.

**DENTAL INSURANCE**

If you have dental insurance we will file the claims for you as a complimentary service. We do ask that the correct insurance information be provided at the time of you appointment in order for us to timely file the claim and collect insurance payments.

Our office will provide you with an approximation of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are **only estimates and are not a guarantee of insurance payment**. We can also send a preauthorization to your insurance as a courtesy.

**Please note that any difference in payment from insurance company is your responsibility**.

**PAYMENT / COPAYS / DEDUCTIBLES**

Payment for copays and/or deductibles (estimated patient portion) is **due at the time the services are provided**.

We offer the following payment options:

1. Payment by cash or Check.
2. Credit card (**Visa, MasterCard and Care Credit**).

**ALL LATE PAYMENTS WILL BE CHARGED A SERVICE CHARGE OF $5.00 A MONTH**

**\*CANCELLATIONS AND BROKEN APPOINTMENTS**

We respectfully request a **48 HOUR CANCELLATION NOTICE**. Cancellations must be made during business hours. Your scheduled time has been saved for you and the doctor and/or hygienist.

If less than 48 hours’ notice is given for an appointment A **NON-REFUNDABLE $50 CANCELLATION FEE** will apply.

**PLEASE LEAVE YOUR CELL PHONE AND E-MAIL SO THAT WE MAY BETTER REACH YOU.**

Cellular\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction.

**Print** Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phillip Zeip DDS 831-475-3853 3315 Mission Dr. Ste. A Santa Cruz, CA 95065**