WOODLAKE
DENTAL CENTER

Jose E. Gallegos, D.D.S. **Scott D. Schlensker, D.D.S**

Financial Policies

The major objective of our office is to provide you with the best quality dental care available anywhere. This service is based on clear communication between our staff and the patient. Please be advised of the following:

- As a courtesy we will file your insurance claim for you. Your insurance policy is a contract between you and your insurance company; therefore, it is up to you to ensure that you are receiving appropriate reimbursement under the terms of your specific plan. If you have any concerns regarding your contracted coverage, we encourage you to verify your benefits with your carrier.
- ***At the time of service, you are responsible for the portion we estimate your insurance will not cover.*** We accept cash, check and most credit cards. Payment arrangements using Care Credit may be made with our financial coordinator prior to scheduling your treatment.
- ***If you have questions regarding a service your insurance did not pay, please contact your insurance company directly.***
- Outstanding account balances will incur finance charges equal to an APR of 24%.
- ***Missed appointments & cancellations with less than 24 hours notice will incur a $50.00 fee per hour of scheduled time.***

AUTHORIZE AND RELEASE:
I understand that responsibility for payment of dental services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered. I understand that I am responsible for any amount not paid by my insurance company. In the event that my account is sent to a collection agency, I will be responsible for all attorney fees, court costs and administrative fees incurred in any legal action. The information that I have given is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions I may have made in completing my information forms for this office. I understand that my signature will be used as "Signature on File" for insurance processing.

ACKNOWLEDGEMENT AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations for you and your dependents. By signing this form you also acknowledge that you have read or been provided an opportunity to read our Notice of Privacy Practices.

This authorization expires three years from the date of signature. You have the right to revoke this Consent by giving us written notice of your revocation. Your revocation is not effective until we receive it at our address below. Revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation. This consent expires three years from the date of signature.

Print Patient(s) Name(s): _____

Signature: _____
(Parent/Guardian if Under 18)

Date: _____

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