Dr. Genevieve B. DeVera and Associates

Financial Policy

I understand and agree that the payment of my bill is my obligation. All filings of insurance papers and confirmation of insurance payments are my responsibility. Any assistance in these matters granted by the doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for filing, follow-through or confirmation. In the case that this account should become delinquent and is placed in the hands of an attorney for collection, I agree to pay attorney fees of 33 and 1/3 percent of the principal and interest balance owing, plus all court costs and a late fee of $5 per month beginning 30 days after the monies were due or expenses were incurred. I further agree to pay returned check charges of $60 per returned check, and a $50 charge per hour of dental treatment if cancellation notice is not given within 24 hours prior to appointment. (We will, however, always be considerate during instances of inclement weather.)

Minor Patients must be accompanied by a parent or guardian for all appointments unless a written consent form is obtained. The adult accompanying the minor is responsible for payment of services.

PATIENT/RESPONSIBLE PARTY SIGNATURE____

PRINT NAME_______________________________________ DATE___________________________

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OPTIONAL

To avoid late fees and delinquencies, our office can keep a credit card number in your file. Please fill out the requested information below, and we will charge your credit card automatically before your account becomes delinquent.

Name (as it appears on card)____

Credit Card number____

Expiration Date___________________**Signature**__________________________________