**Family Dentistry By Baria yassin, D.M.D**
**6500 S.Padre Island suite #16.**
**Corpus Christi, Tx 78412.**

## Our Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.
All patients must complete our information and insurance before seeing the doctor.
**Full payment is due at time of service.We expect you to leave a current credit card number on file to be used automatically only in case of an outstanding balance of over 30 days.**
**We accept cash, checks, or credit card.**

### Regarding insurance

We may accept assignment of insurance benefits after verification of benefits. However, we do require 50% of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you give us all the information necessary. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be your responsibility.
All co-pays and deductibles are due at the time of service. We are not allowed to combine two insurance types to lower your co-pays or deductibles.

### Usual and customary rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of insurance company's arbitrary determination of usual and customary rates.

### Minor patients

The adult accompanying a minor and the parents (or guardians of the minor) is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by the parents.

### Bad Debts

Due to the requirements of the law, it is necessary for you to sign a statement that in the event we must bill you or turn your account over to a third party for collection, we have informed you that you are responsible for ALL COSTS, INCLUDING BUT NOT LIMITED TO BILLING, COLLECTION AGENCY'S FEES, AND ATTORNEY'S FEES.

### Missed Appointments

Unless canceled at least 24 hrs in advance, our policy is to charge for missed appointments at the rate of $25.00 per missed office visit. Please help us serve you better by keeping scheduled appointments.
Thank you for understanding our Financial Policy.Please let us know if you have any questions or concerns.
I have read the Financial Policy.I understand and agree to this Financial Policy.

x---------- Date:----------
signature of patient or Responsible Party