HERNANDEZ DENTAL
81-719 DR. CARREON BLVD #C
INDIO CA. 92201
(760) 347-7196

FINANCIAL POLICY

Thank you for choosing Dr. Hernandez as your Dental provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment needed to restore your dental needs. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate calling our office.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services rendered is due at time of service. We accept cash, check, and for your convenience, MasterCard, Visa, and Discover. We now also offer CareCredit as an option to our patients. We will be happy to help you process your insurance claim for reimbursement. However, you must understand that:

1. Your insurance policy is a contract between you and the insurance company. We are **NOT** a party to that contract. **OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY.**
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts.
3. Fees for these services, along with unpaid deductibles and co-payments are due at time of service. NO EXCEPTIONS WILL BE MADE.
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help expedite the process.
5. You need to cancel your appointment **24 hours** in advance or there will be a fee of **$20.00** for cancelled appointment. This will increase to **$70.00** if you are scheduled for appointments with larger treatment.
6. If a balance is remaining after **90 days**, interest will start to accrue at the rate of 18%.

We understand that temporary financial problems may affect timely payment of you balance, we ask you to call our office as soon as possible.

Again, thank you for choosing us as your dental care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

ASSIGNMENT AND RELEASE: I hereby authorize payment to be made directly to my account and fully understand that I am the responsible party for all dental bills incurred by me at the above mentioned facility. I also authorize the release of any information required for the processing of this claim. If legal action becomes necessary to enforce payment, I agree to pay a reasonable attorney fee

Patient/Responsible Party

Signature:_____Date:_____