Patient Financial Responsibility Agreement

Thank you for choosing Echeverri Dental Center for your dental care. We strive to establish the best possible relationship with our patients, in order to do that, we ask that you read and understand our policy regarding payments and insurance.

Patients are fully responsible for all charges from treatment provided. If patient has insurance, this includes the remaining balance after payment of insurance allowance.

If you do not have dental insurance, please skip to last page.

Patients with insurance

I understand that my insurance policy is an agreement between my insurance and myself. I am fully responsible for all charges from services rendered to me, including the balance remaining after payment of insurance allowance.

Our Insurance Coordinator will contact your insurance and gather all the information regarding your allowance. This will let us make an estimation regarding your proposed dental treatment.

In case it is necessary, or you require it, we will file a pre-determination to your insurance. If you request a pre-determination, we will not proceed with treatment until a response is received from your insurance.

Filing claims to insurance companies is courtesy that we offer all our patients. EDC only files claims to primary insurances.

Since the information we receive from your insurance company is an estimate, we request that you leave a credit card on file. The credit card will only be automatically processed in the event there is an outstanding balance of $100 or less, after your insurance pays. For amounts greater than $100 we will contact you.

All co-pays and payments are due at the time of service.

By signing, you are agreeing to EDC Patient Financial Responsibility Agreement. Make sure to ask all questions and clarify concerns before signing.

_____	_____	_____
Patient name	Signature	Date
_____	_____	_____
If patient is a minor, name of responsible party	Signature	Date

Patients without insurance

Patients are fully responsible for all charges from treatment provided.

_____	_____	_____
Patient name	Signature	Date
_____	_____	_____
If patient is a minor, name of responsible party	Signature	Date

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