Newbury Park
DENTAL ARTS

To Our Valued Patients:

We would like to welcome you to our office. Please take a few moments to read the following with regard to our payment policy.

If you have no dental insurance, payment in full is required at the time of service.
If you have PPO dental insurance, we will be happy to bill your insurance company for you. Your estimated patient portion of the fee will be due at the time of service.

We are not currently contracted with any HMO or DPO plans or dental groups. If your insurance is with an HMO or DPO plan, we will consider your account with us as "cash" and payable at the time of service.

Please understand that we cannot always discern from your insurance card the exact plan in which you are enrolled or the exact benefits that you are eligible for. You will need to be familiar with your dental coverage specifics. We always welcome questions and are available to help you understand your insurance if we can. If you need to make financial arrangements, please speak with us prior to your appointment time.

We request a **48 hours notice** if you need to cancel or reschedule your dental appointments. Broken appointment fees with less than 48 business hours notice (not including Fridays) or "no show" appointments will be charged the rate of **$75 per hour** reserved.

Initials

_____ I have read and understand the above material and agree to its standards.

_____ I have received the Notices of Privacy Practices.

_____ I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs/my child's dental needs.

_____ I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administration claims for insurance benefits. 1, the undersigned, grant permission to Newbury Park Dental Arts and Dr. Cristina Markiewicz to utilize my x-rays and/or photos for advertisement, social media & educational purposes as needed.

Patient Name: _____

SIGNATURE OF PATIENT, PARENT OR GUARDINAN _____ **DATE:** _____

Printed Name: _____