SANTA TERESA DENTAL CENTER

Financial Responsibility Statement

The following information is provided as a service to you, our patient. Please understand that treatment costs are your personal responsibility. Professional services are rendered and charged to the patient, not to the dental insurance company. We cannot render services on the assumption that our charges will be paid by an insurance company. This estimation depends totally upon the accuracy of the information supplied by your insurance company and the deductible, maximum benefits, etc., for the specific insurance group coverage and patient. Payment of estimated share is due at the time of service. We will bill your insurance carrier as a courtesy.

Scheduling Appointments

When you commit to an appointment, that time is reserved just for you. Therefore, we kindly request at least 48 hours notice be given if cancellation is absolutely necessary so another patient may benefit from your time reservation. The office reserves the policy and authority to charge patients for appointments that are missed or canceled.

Authorization for Release

I hereby authorize the release of any and all information, acquired in the course of my examination/treatment, to my insurance company. I hereby authorize and request the payment of dental benefits directly to Lakshmy Sudeep, D.D.S., for dental services rendered to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Signature_____

Date Signed_____