Brent C. Lay, D.D.S.
24900 Highland Way
Los Gatos, CA 95033
(408)353-1191

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

Please Note: Payment is due at the time of service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and Care Credit.

Do you have Insurance?

- As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you: however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
- 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 any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by the insurance company, by cash, check, MasterCard, Visa, Discover, and Care Credit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made a payment within 60 days, we ask you to contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

Patient Signature: _____Date: _____

Print Name: _____

Guardian/Responsible Party, if minor: _____Date:_____

Print Name:_____

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- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over a claim.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service. **Unaccompanied Minors:** The parent or legal guardian is responsible for full payment at the time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

Missed Appointments (s) and Cancellations:
Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best service to our patients, we require at least a 48 hour business days' notice for cancellations or for re-scheduling your appointments. We understand unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge of $150 an hour may be assessed for missed, short notice or cancelled appointments. Multiple failed appointments may result in you paying a deposit ahead of your scheduled appointment.

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or

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diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a **$25.00** returned check fee. For any payment that I make by credit card or by debit card to the dentist or any collection agency to which my account has been assigned, I authorize the dentist or collection agency to add to each such payment the fee or charge actually incurred by the dentist or collection agency for processing the credit card or debit card payment not to exceed $10 per payment.

Any account balances that remain unpaid for **60** days from the date of service shall accrue interest at the rate of **1.50%** (**18%**) per year and may be referred to a collection company or an attorney. In the event this occurs, I understand that I will be liable for collection costs of $100.00. Additionally, in the event any unpaid account balance is referred to an attorney for collection by the dentist or a collection agency, I agree also to be responsible for all costs and reasonable attorneys' fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me, and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred (a) by mail at any address that I provide to the dental office and/or (b) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient Signature: _____Date: _____

Print Name: _____

Guardian/Responsible Party, if minor: _____Date:_____

Print Name:_____