Fiesta Dental

9355 Bandera Rd. Ste.106
San Antonio, Texas 78250
(210) 509-0300

Consent for Services and Financial Policy

In an effort to make dentistry more affordable to you, we participate with certain Dental Insurance programs. Dental Insurance allows for your reimbursement of a percentage of fees for service. We will help you receive maximum benefits under your policy. Please remember that the amount of your insurance coverage is only an estimate. The patient is responsible for all treatment or charges not covered by insurance. If we accept benefit assignment, as a service to you, we ask you provide complete insurance information and pay your deductible amount and estimated portion at the time of service (some procedures require 50% or more payment). **The patient portion is an ESTIMATE ONLY.** If your insurance company has not paid the **FULL BALANCE** within 45 days, you will be given 30 days to complete payment or make financial arrangements for the balance. If your insurance pays more than the balance due, we will send a refund check to you at your request, or credit patient/family account. **Insurance is never a guarantee of payment of benefits; therefore service not covered or denied for any reason will be your responsibility.**

We file claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information. This is your insurance plan. If you have any questions regarding your coverage, please contact your company or employer's Human Resource's department.

Please indicate by your signature below that you understand and agree to abide by this Financial Policy. If you have any questions or concerns regarding this Policy before you begin your treatment, we are here to serve you and happy to help you.

Patient's Name: ____________________________________
Signature of Responsible Party: _______________________________
Date:___________________

Acknowledgment of Receipt of Privacy Practices*
(*Privacy Practices are attached to the clip board*)

I, ___________________________, have had the opportunity to review or have received a copy of this office's Notice of Privacy Policy.

________________________ Date: __________ Relationship to Patient: _________________
Signature of patient or legal guardian (if patient is a minor)