Miguel Angel Lopez Jr, DMD, PA
Family Dentistry

FINANCIAL POLICY

Dr. Lopez and his staff would like to thank our current patients and welcome our new patients to our office. Our goal is to provide you with excellent dental care, while making your visits as convenient as possible.

By signing below, you confirm that you have read this policy and understand that:

- Your account is to be kept current, all self-pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service. Payable by cash, check, or credit card.
- It is your responsibility to inform us of any address or telephone number changes.
- If your account becomes delinquent, your appointment may be rescheduled.
- A returned check will result in $30.00 service charge and all future payments being required in the form of cash or credit card.
- Refund checks will be issued for credit amounts over $10.00. If your credit is less than $10.00, that balance will be applied to future visits**. Refunds will be issued within 6 weeks from the date requested, if there are no pending insurance claims.**
- Any unpaid balances older than 30 days may be subject to 1.5 % interest per month.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

If you have dental insurance coverage:

Our relationship is with you, not your insurance company. It is your responsibility to be familiar with your dental insurance coverage (what your plan covers and what it does not cover). We will help you with this. We are responsible for correctly filing your claim. You are responsible for payment to us for services rendered, whether the payment comes from your own money or from the insurance company. All charges are your responsibility from the date services are rendered. You are responsible for any non-covered charges not payable by your insurance policy.
If your insurance has not paid within 60 days from date of service, you will need to make full payment to this office. If your insurance pays us after this time, you will be reimbursed. After 60 days the patient is responsible to pursue payment from the insurance company. All necessary documentation will be provided to you to assist your inquiries, if needed.
If you have any questions, please do not hesitate to ask our office manager.

I have read and understand the above Financial Policy and agree to meet all my financial obligations.

Patient Name (please print)	Patient Signature	Date
Responsible Party (please print) (if other than a parent)	Responsible Party Signature	Date