

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Address: _____
Street Apartment #
City State Zip Code
Home Phone: _____ (Work): _____ Ext: _____ Cell Phone: _____
Best phone number to reach you at: _____ email: _____
I agree to information by email: _____
Social Security #: _____ Drivers License#: _____ Gender: _____ Birth Date: _____

How did you hear about our office? _____
Whom may we thank for referring you to our practice? _____

Responsible Party - If Different from Patient Information

Name: _____ Relationship to patient _____
Last, First MI (Preferred Name)
Address: _____
Street Apartment #
City State Zip Code
Home Phone: _____ Work: _____ Ext: _____ Cell Phone: _____
Best phone number to reach you at: _____
I agree to information by email: _____ Email: _____
Social Security#: _____ Driver's License#: _____ Gender: _____ Birth Date: _____

Employment Information

The following is for: the patient the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Phone: _____

Insurance Information

Primary Insurance Company: _____ Group Plan Name: _____
Name of Insured: _____
Last, First MI
Insured's Birth Date: _____ Social Security/ID # _____ Group#: _____
Insured's Address: _____
Street Apartment # City State Zip Code
Insured's Employer Name: _____
Address: _____
Street Apartment # City State Zip Code
Patient's relationship to insured: Self Spouse Child Other
Secondary Insurance Company: _____ Group Plan Name: _____
Name of Insured: _____
Last, First MI
Insured's Birth Date: _____ Social Security/ID # _____ Group#: _____
Insured's Address: _____
Street Apartment # City State Zip Code
Insured's Employer Name: _____
Address: _____
Street Apartment # City State Zip Code
Patient's relationship to insured: Self Spouse Child Other

JOSE L. BANDALA, DDS – OFFICE FINANCIAL POLICY

Patient's Name: _____

Birthdate: _____

We strive to provide the best dental care for our patients and try to take into consideration all circumstances involving each patient and their ability to receive their needed dental care. In order to provide our patients with this level of quality care, it is necessary to set financial policies that will enable us to keep our fees reasonable for all our patients. This includes limiting the expense of billing patients for treatment rendered and carrying balances in this office.

Financial Agreement

Initials _____

We, the staff of Bandala Dental Group thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and look forward to doing so. We are committed to providing you with the highest level of care to build a successful Provider-Patient relationship with you and your family. We believe your understanding of our financial policy is vital to this relationship. As our goal is to keep open communication with our patients, please feel free to contact us at (916)782-0440 or bandaladds@gmail.com if any questions or concerns regarding fees, policies, or responsibilities may arise.

Initials _____

Please understand that payment for services is an important part of the Provider-Patient relationship. Payment for services is due on the date of service. If you are using insurance, we will contact the insurance carrier for a breakdown of coverage. You will be responsible for your **estimated** portion. The insurance will be billed for what is their estimated portion. Any amount not paid by the insurance is the patient's responsibility to pay in a timely manner. We make payment as convenient as possible by accepting cash, money orders, and most credit cards. A \$35.00 service fee will be charged for all returned checks.

Insurance

Initials _____

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy bill your insurance to help you receive maximum allowable benefits under your policy. We have found that patients who are involved in their claim process are more successful at receiving prompt and accurate payment of claims. It is the patient's responsibility to provide all necessary insurance information. **Also, please be aware that even a pre-determination of service does NOT guarantee payment from your insurance carrier.** It is the patient's responsibility to know if our office is in or out of network. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles as outlined by your insurance carrier.

Missed Appointments

Initials _____

We require notice of appointment cancellations or changes 48 business hours in advance. We are open Mon-Thurs so to change an appointment for a Monday we would need to know by the prior Tuesday in order to avoid a charge. This allows us to offer the appointment to another patient. If you miss your appointment and/or fail to give 48-hour notice, you will be charged a fee of \$95 per hour scheduled. If you are changing your appointment for a Monday or Tuesday, we will need to know the Wednesday before to avoid a charge. Repeated missed appointments without notification or failure to pay fees incurred may result in you being discharged as a patient so that we can provide care to other patients.

JOSE L. BANDALA, DDS – OFFICE FINANCIAL POLICY

Medical Records

Initials _____

Patients are entitled under Federal Law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient's rights. However, providers also have the right to compensation for records. Our fees are reasonable cost-based for copies, supplies, labor, and postage.

Timeliness of Appointments

Initials _____

We try to see everyone in a timely manner. Unfortunately, the dental field and patient's individual needs can change without notice causing delays in the schedule. If we are taking too long, please let us know so that we can best serve your needs and reschedule you if necessary.

We realize that temporary financial problems may affect timely payments on your account. Please remember to always communicate with the office so that we can assist in the management of your account.

I have read and understand the above financial policy. I agree to assign insurance benefits to Bandala Dental Group whenever applicable. I also agree, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for costs of collection if such action becomes necessary.

Patient's Signature: _____

Date: _____