PENINSULA
DENTAL CARE
RAMIZ R. PETROS, D.M.D
(650) 701-1122

FINANCIAL POLICY

Thank you for choosing Peninsula Dental Care as your dental provider. We are committed to the success and quality of your treatment.

PARIENTS WITH DENTAL BENEFITS

The benefits provided by your dental insurance company are provided in order to aid payment for dental treatment, and are not intended to cover all dental treatment in full. We cannot guarantee that your dental insurance provider will coverall services offer in this practice. Your insurance policy is a contract between you and your employer. Peninsula Dental Care has no ruling over the benefits provided.

After a claim has been received and processed by their limited benefits, the insurance carrier might reimburse you directly. **Patients with any other insurance carrier must pay their co*pay and or deductible at the time of treatment.**

PAYMENT OPTIONS

1) Pay for treatment rendered at time of visit. We accept Cash, Check, Debit, Visa, MasterCard, American Express, and Discover Card.

2) If your treatment plan totals $500.00 or higher, you may prepay your treatment plan in full, with **cash** or **check**, and receive a 10% administrative courtesy discount, or pay with a **credit card** and receive a 2% discount.

3) If your treatment plant totals $1000.00 or higher, we offer an extended payment plan. Minimum monthly payments will be determined according to credit approval. (Credit Card refund will be subject to 10% reduction, in the form of a check)

LATE PAYMENTS

If you do not pay your balance within 30 days of the billing date, a service charge of 1.5% will be added to your account. You are responsible for payment regardless of your insurance company arbitrary determination of usual and customary fees.

NSF CHECKS

Return checks will be charged a Non-Sufficient Funds fee of a minimum of $25.00, plus the value of the check.

MISSED AND CANCELLED APPOINTMENTS

Peninsula Dental Care requires a **minimum 48 hours** (or by 12pm on a Friday or Monday appointment) for canceled appointments. **If we are not notified within this time frame, you are subject to a $75.00 charge per missed or canceled appointment.**

I, (your name) _____,have read the above information and receive a copy of privacy Act Acknowledgment. I understand and agree to Peninsula Dental Care's financial policies.

_____ _____

Signature of Patient or Responsible Party Date