James T. Jesse D.D.S., Inc.
909-799-9988

328 E. Commercial Rd. STE 104
San Bernardino, CA 92408

FINANCIAL AGREEMENT

Patients without Dental Insurance: Payment in full is expected at the time services are rendered. We accept cash, all major credit cards, and Care Credit.

Patients with Dental Insurance: As a courtesy to you, our office will gladly submit to your dental/medical insurance. We are able to bill all traditional indemnity plans. We do **not** accept DMO/HMO plans. Under these plans there is **NO COVERAGE** when treatment is rendered by a non-participating dentist. Please check your plan carefully. We are a participating provider with **Delta Dental PPO & Risk Management** Insurance. For **all other PPO plans**, James T. Jesse D.D.S., Inc. is **out of network**. We are still able to bill your insurance and benefits are payable, however they may pay at a lower percentage or amount. For more specific information about out-of-network benefit amounts, please call your insurance company.

Authorization to Release Info & Assignment of Benefits: I certify that I _____ *(or my dependent)* have *(has)* dental insurance coverage and assign directly to James T. Jesse D.D.S., Inc. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor and/or his staff to release all necessary personal information to the insurance company in order to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Payments: We accept cash, all major credit cards, and Care Credit. Payment of your "**ESTIMATED**" portion is due at the time services are rendered, such as annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide an estimate of your patient portion. We cannot guarantee the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Keep in mind that many insurance companies base their quoted percentage of coverage (i.e. 100%, 80%, etc.) on their own fee schedule and not our actual fees which may result in a balance due higher than expected. Should an outstanding balance result after your insurance company processes the claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement.

Past Due Accounts: If payment is not received by the due date on the statement, then your account is considered "past due." We reserve the right to charge $5.00 per month for bill charges on all past due accounts. If the balance is still unpaid, and no attempt made to communicate with our office regarding alternative arrangements, we will pursue legal collection processes through either an attorney or collection agency. If an account is turned over to a collection service, the account holder will be held responsible for all fees involved in said process. We do not want to cultivate a contentious relationship with our patients and hope that all financial issues will be discussed with us fully.

Broken/Missed Appointments: We request a 24-hour notice for cancellations or rescheduling an appointment. As a courtesy to you, we will make every effort to confirm your reserved appointment. If our attempts are unsuccessful, it is still your responsibility to keep your reserved appointment or contact us 24 hours in advance to change or cancel the reserved time. All patients who fail to arrive for their reserved appointments or who cancel without 24 hours advance notice will be charged a $50 missed appointment fee.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am financially responsible for all dental services rendered to me and my dependents.

Patient Name_____ Date_____

Responsible Party Signature_____ Relationship to patient_____