AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

_____ I hereby authorize

Patient's name

Isabel Perez D.D.S. and Fernando Caballero D.D.S. and any associates to perform any and all dental procedures/treatment deemed necessary. I understand that perfect results of such proposed treatment are not guaranteed or warranted but that every effort will be made to resolve my dental issues in the best and most cost effective manner possible. It is my responsibility to discuss, to my satisfaction, the following issues with regard to my treatment:

- The nature and characteristics of the proposed treatment
- The anticipated results of the proposed treatment
- The professionally recognized alternative forms of treatment
- Any and all known possible serious risks and/or complications of the treatment and of the recognized alternative forms of treatment for my condition, including non-treatment.

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I acknowledge that I am responsible for payment of all services rendered by **Isabel Perez D.D.S. and Fernando Caballero D.D.S.** and their associate dental care providers. I agree to pay all charges at the time of service unless alternative arrangements are agreed upon in advance.

I understand that when I schedule an appointment, it is time specifically reserved for me. If I fail to show up for an appointment or fail to cancel/reschedule at least 48 hours prior to the appointment, I will be charged a $50.00 missed appointment fee and will pay that fee.

A note about insurance…

As a convenience to our patients with dental insurance, our office will submit the charges for your treatment to your insurance company at no extra cost.

Please understand that your coverage is a contract between you and the insurance company. No insurance company covers 100% of all procedures with no limitations. Some companies pay fixed allowances for certain procedures and others pay a percentage of the costs. All policies have maximum limitations on the amount they will pay out for each patient within the policy year.

It usually takes 3 to 6 weeks for benefits to be paid. If, after 60 days, the insurance company has not paid, we ask the patient to pay the balance of his/her account. We will continue to seek settlement from your insurance company for a reasonable period of time. It may well be necessary for the policyholder or patient to contact the insurance company to expedite payment.

Notice: Do not sign this agreement without reading it. Your signature indicates your agreement to the conditions set forth. You are entitled to a copy of this agreement. Please don't hesitate to ask the doctor or staff if you have any questions.

Signature:

Date: