Financial Responsibility

It is our policy to discuss our fees and financial arrangements open and honestly with you. Regardless of whether you have dental insurance or not, YOU are responsible for the full financial cost of dental treatment.

If you have dental insurance all deductibles, co-payments, and portions of your bill that insurance does not cover are due at the time of service performed, unless financial arrangements have been previously made with our office.

For your convenience, we gladly accept personal checks, and most major credit cards. We also offer dental financing through Care Credit interest free payment plans.

If you have dental insurance, every effort will be made to ESTIMATE the portion of the total cost that may be covered by your dental insurance plan. Our office will process an insurance claim for payment of dental treatment directly to us. You will then pay only your portion as discussed on your financial arrangement plans.

If we process your insurance claim, we will wait up to 30 days for payment from your insurance company.

If we have not received payment, we will then bill you and have you contact your insurance company for payment of their portion to you.

If we process your insurance claim and payment is DENIED or is LESS than our estimate of your Insurance coverage, you will be billed the remainder. You have 30 days to pay your balance. Delinquent accounts will be charged a late fee of 1.5% per month. After 90 days of non-payment of your balance we will inform the collections agency for further actions.

If you receive any communication from your insurance company about fees and / or dental services performed, please contact our

office immediately.

When benefits are assigned directly to this office, if the insurance company sends a check to you in error, we will hold you responsible for immediate and complete reimbursement. If the insurance company has not paid the entire benefit available, we will hold you directly responsible for payment of the outstanding amount.

At any point during treatment, if the insurance company becomes uncooperative, we reserve the right to refuse to work with that insurance company and will look to you for payment of the remaining balance and you will have to settle with your insurance company.

If you have or do not have dental insurance, payment of all services are due at the time of service.

Office Policy & Fees for Duplication of Patient Records

Our dental office shall at all times honor patient requests, whether verbal or in writing, for a copy of dental records in compliance with Texas State law, and pursuant to the Rules of the Texas State Board of Dental Examiners, which states that patients are entitled to a copy of their records within 30 days of the request, and subject to costs of duplication established by Board rule.Rule 108.8 of the Rules of the Texas State Board of Dental Examiners provides as follows:

1 We shall furnish copies of dental records to a patient who requests his or her dental records.

2.Requested copies including radiographs shall be furnished within thirty (30) days of the date of the request, provided however, that copies need not be released until payment of copying costs has been made.

3.The dentist providing copies of patient dental records, either electronically or paper form, is entitled to a reasonable fee for copying which shall be $25

4.Fees for radiographs copied electronically or paper form will be

minimum $15, and anyother additional charges that might be incurred to perform the copying procedure.

The mouth, gums, and teeth are constantly changing due to the progressive nature of dental disease. The actual costs of dental treatment may differ from the estimate due to our treatment of this progressive dental disease. In the event the actual costs of dental treatment differ from the estimated costs, you will be responsible for any additional cost. Every effort will be made to notify you if this occurs.

I am aware that any scheduled appointment is reserved for me exclusively, and in case of cancellations I will notify the office at least 24 hours BEFORE the appointment date. I am aware that the failure to keep my appointment, for ex. as a no show, or cancelling within 24hours of my appointment date will incur a $35.00 cancellation/no show fee in my account. I ALSO UNDERSTAND THAT SATURDAY APPOINTMENTS REQUIRE 48HOURS NOTICE OF CANCELLATION, FAILURE OF WHICH FOR EXAMPLE AS NO-SHOWS, CANCELLING IN LESS THAN 48HOURS, WILL RESULT IN A CHARGE OF $50.00 AND NO FUTURE SATURDAY APPOINTMENTS.

I __#RP_FIRST_NAME# #RP_LAST_NAME#__ certify that I/my spouse/my dependent (child)_#PAT_FIRST_NAME# #PAT_LAST_NAME#__is covered by _#PRIM_DEN_CARR_NAME#__Insurance Co. and I assign all insurance benefits directly to Dr. Shalini Thasma DDS. I understand that I am responsible for payment of all services rendered and am also responsible for paying co-payments, deductibles AND any other amount that my insurance does not cover. I hereby authorize Dr. Thasma to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I assume financial responsibility for the above named person. I understand that payment is due on the day services are rendered. I authorize Dr.Shalini Thasma D.D.S., DONTIA PLLC, to collect payment from the insurance company. I understand that the insurance company may pay only a portion of my bill and that ultimately I am responsible for the full payment.

Thank you for selecting our office. We hope that should you have any questions regarding finances, financial arrangements, or dental insurance, you will feel free to talk to us at any time.

Patient’s Name

Responsible Party Name

Relationship to patient