

Fabrizio Dall'Olmo, D.D.S. & Farinoush Gaminchi, D.M.D.
Periodontics & Implant Dentistry

7721 South Painter Avenue, Whittier, CA 90602
(562) 693-2741

Financial Policy

Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs. We are committed to providing you with the highest quality dental care using only the best materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health.

Payment in full is due at the time we provide service. Our office accepts cash, personal checks, Master Card, Visa, American Express and Discover. If you have dental insurance and you bring proof of dental insurance to our office, as a courtesy we will process your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the below Assignment of Benefits Agreement. All changes you incur are ultimately your responsibility, regardless of insurance coverage. **We must emphasize that as your dental care provider, our relationship is with you – our patient, not with your insurance company.** Our office is not a party to that contract or to any possible restrictions.

Returned checks and balances older than 30 days may be subject to collection fees and finance charges at the rate of 2% per month (29% annually). Additionally, charges may be incurred for broken appointments and appointments cancelled without 48-hour notice.

Signature of patient/Responsible Party

Date

Assignment of Benefits Agreement

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

Although we are willing to complete insurance information forms and submit a claim on your behalf as outlined above, we do not accept responsibility for the outcome of the transaction. We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office. In addition, we require you to pay your co-payment, which is the amount not covered by your insurance company, at the time we provide service. Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 120 days, we will ask you to pay the balance due at the time. You will be responsible for seeking reimbursement from your insurance company at that time.

Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. If your claim is denied, however, you will be responsible for paying the full amount at that time. Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or question that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I have read and understood the above conditions. I hereby authorize my insurance company to pay my dental benefits directly to the doctor.

Signature of patient/responsible party

Date

If you have any questions regarding our Financial Policy or Assignment of Benefits, please ask. We are committed to providing you with the most positive experience in dental care.