OFFICE POLICIES FOR ZINNIA CARLOS REGALA, D.D.S. AND ASSOCIATES

Welcome to our dental practice! We are delighted that you have chosen our office to care for your family's dental needs. It is the intention of the following office policies to assist in making your treatment as pleasant and efficient as possible. Please help us to help you!

I. Payments and Charges:

1. All **New Patients** will be required to pay for services rendered on the first visit. If you have insurance, your insurance will be billed for the full amount of the treatment, and the office will reimburse you when they send us payment.
2. Your time is valuable and Dr. Zinnia & Associates conscientiously take patients on time for their appointments. Please be considerate of our time by giving us a 24 hour notice of cancellation. Failure to do so will result in a **$50** charge.
3. I.V. sedation appointments will require a $250 deposit in order to reserve a specified time. **(SEE I.V. SEDATION POLICIES)**

II. Insurance

1. As a **courtesy** to our patients, we will bill your insurance company for you but will require your portion and/or deductible at the time of each visit.
2. The office will bill you directly for any portion owing that insurance has not covered. **You are ultimately responsible for your account.**
3. Should your insurance company reimburse you directly **(i.e. Blue Shield)** payment will be expected **IN FULL** at time of each visit.

III. Overdue Accounts

1. Payment arrangements can be made **in advance** with the office manager in order to keep your account current.
2. Please help us in keeping your accounts current. Accounts over 90 days will be sent to collections.

IV. Parents

OUR OFFICE ASKS THAT YOU, (AS THE PARENT OR LEGAL GUARDIAN), MUST ACCOMPANY YOUR CHILD AT ALL DENTAL VISITS.

I have read and understand the office policies and agree to adhere to them. My signature below authorizes and serves as assignment of benefits from my insurance company and that payments be made to this office directly, for services administered to patient.

_____ _____

Signature of Parent or Legal Guardian Date