Dental Practice of Dr. Varo Boyer D.D.S. Inc.
1720 E. Los Angeles Ave #224
Simi Valley, CA 93065
805-581-0144

Financial Consent Form

NOTE: We request at least **24 hours notice** for any cancellations. Our policy for same day cancellations is a charge of **52.00**. Please initial here____

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I authorize the doctor to perform all recommended treatment mutually agreed upon by the patient, as well as use the appropriate medication and therapy indicated for such treatment in connection with the patient.
3. I understand that all responsibility for payment of dental services provided by this office for myself/ a dependent is **my** responsibility.
4. I understand that it is my responsibility to advise the office of any changes in the information on my patient form.

Financial breakdown

As a condition of treatment by this office, financial arrangements must be in advance. The practice depends on payment from the patient for the costs incurred in their care. Financial responsibility will then be discussed with each patient before treatment.

All emergency services must be paid at the time of service, unless previous arrangements have been made.

DENTAL INSURANCE- We bill to dental insurance as a courtesy to our patients. A breakdown of estimated patient portion is discussed before treatment is done. We do our best to provide accurate estimates of the patient portion. There are times where there is a difference of amounts paid. At this time the patient will be notified of the remaining balance. Any remaining balance after insurance payment is the **patient's responsibility**. If the patient happens to overpay for a service the patient will be notified of the credit on the account.

Finance charges are applied when a patient has a balance and there is no show of payment for at least **60 days**. We understand that some services are costly and cannot always be paid up front. Please call our office to make payment arrangements if this is the case.

I understand that any procedure estimate can only be extended for 1 year. After this time, the fees may have changed and I will need an updated estimate.

I give my permission to you to discuss my treatment or billing questions by phone or email.

[_] I have read the above conditions of treatment and payment; I agree to their consent.

Patient/ Responsible Party _____

Date_____