AZ Dental Health Inc.
Jeffrey B. Pico, D.D.S
2500 S. Power Rd. Suite 105
Mesa, AZ. 85209

Office Financial Policy

Thank you for choosing Dr. Pico as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

- **All Patients** must complete all Forms prior to being seen by the Doctor
- All treatment estimates are good for 90 days.
- **Full Payment** is due at the time of service. We accept cash, check, Visa/Mastercard Discover, and American Express
- A $25.00 Charge is incurred for returned checks and ALL future appointments must be paid in cash at the time of service.
- An APR of 22% will be automatically added to ALL unpaid balances over 30 days. Any balance left unpaid after 90 days will be turned over to a collection agency and patient will be dismissed from the practice.

Regarding Insurance

We accept assignment of insurance benefits. The balance is YOUR RESPONSIBILITY whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that the estimates that we give you are just that. We do not guarantee ANY insurance coverage. Please be aware that some or all of the services provided may not be covered services. ***It is your responsibility to find out what is and is not covered***. You will be responsible for any balance not paid by your insurance company.

Adult Patients

Adult patients are responsible for full payment at the time of service.

Minors

The adult accompanying a minor to his/her appointment is responsible for payment at the time of service. Minors will not be treated if unaccompanied or if arrangements have not been made prior to the time of service.

Missed Appointments

Unless cancelled AT LEAST 24 HOURS IN ADVANCE, our policy is to charge for missed appointments at the rate of $40.00 per hour. This will help us cover a portion of our costs for the time *reserved especially for you*. Please help us serve you better by keeping your scheduled appointments! Excessive missed or canceled appointments will result in dismissal from the practice.

Thank you for understanding our Office Policy. Please feel free to let us know if you have any questions or concerns.

I have read, understand and agree to the above financial policy.

Patient or responsible party _____Date_____