
PATIENT ACKNOWLEDGEMENT.

___ It is your responsibility to provide the office with complete/accurate insurance information at the time of your visit. Dual coverage informations if any. Denial of payment due to not being given the proper information will become your Financial responsibility. It is important that you know your insurance plan.

__ YOUR ARE RESPONSIBLE to know if your insurance has maxed out or will maxed out with futureappointment. If your insurance denied payment due to “insurance maxed for the year” you will be responsible for those sevices.

__ For my convenience, this office may release my information to my insurance company and I authorized for the dental office to receive payments directly from insurance company.

__ I understand that if I begin major treatment and involve any of copay/lab work, I will be responsible for the fees at the time of service. The office policy requires that I pay my estimates portion at the time of service.

__ I understand that the “ESTIMATE” for my portion of benefits at the time of service can be different after dental office submitted and processed with insurance. The dental practice can not GUARANTEE that they can provide 100% accuracy ot the estimate due to many factors.

__ I understand that office do not offer any sort of payment plans and accept all major credit cards and Care credit.

__ If I sent to collection, I agree to pay all related Fees and court costs.

__ I understand that office has 48 hours notice of cancellation. I will pay the fee of $50.00 for any broken appointment without 48 hours notice.

__ I understand the fee estimate listed for this dental care only be extended for a period of 6 months from the date of examination. I will take responsible for my oral health by refused any treatment that has been thoroughly discussed to me by Dr Hermo.

__ I grant my permission to Tooth Spa Dentistry to call, Email, or text me to remind my up coming appointment, pending treatment or any discussion that office has regarding to my oral health .

Signed:_____ Name: _____Date:_____

Irene Hermo, DDS 831 Sterling Parkway 130 Lincoln CA 95648

Phone: 916 209 3708 Fax : 888 858 1377 Email: Lincoln@toothspadentistry.com