American Canyon Dental Care
Julia Villa DDS Inc
3431 Broadway Suite A7
American Canyon, CA 94503
707.557.5057

Patient Financial Agreement

Release of Information for Reimbursement: To the extent necessary to obtain reimbursement, the practice may disclose any portion of the patient's medical record, including his/her medical records, to any party the patient has identified as liable for any portion of the office's charges, including but not limited to, insurance companies, healthcare service plans, workers compensation carriers and referred dental practitioners. You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us.
The undersigned have read this disclosure and agree that the Lender/Creditor and its agents may contact me/us as described above.

Financial Agreement: The undersigned agrees, whether he/she signs as agent or as a patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the practice in accordance with the regular rates and terms of the practice. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Assignment of Insurance Benefits: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the practice of any insurance benefits otherwise payable to the undersigned for services rendered at a rate not to exceed the practice's usual and customary charges. It is agreed that payment to the practice, pursuant to this authorization, by an insurance company/Dental Insurance Plan shall discharge said insurance company/Dental Insurance Plan of any and all obligations under policy to the extent of such payments.

It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

Dental Insurance Plans: The Practice is contracted with multiple Dental Insurance Plans. It is the undersigned's responsibility to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Dental Insurance Plan limit, reduce or deny coverage of dental services at the facility. The undersigned agrees that he/she is obligated to pay the practice at time of service for any deductible, copayments, coverage penalties, or for any service rendered which is not a covered benefit of his/her plan Dental Insurance Plan at the practice. For non-emergency services, it is the patient's responsibility to ensure his/her plan has authorized the requested services at the facility.

The undersigned agrees that denial of payment for lack of an authorization for non-emergency services will be considered a denial for non-covered benefits, and payable by the undersigned.

Appointments:
To avoid a minimum of a $35 appointment cancellation fee, please provide us with a 48 business hours advance notice of any changes.

The undersigned acknowledged he/she has read and understands the financial agreement, assignment of insurance benefits, Dental Insurance Plan obligation and all other applicable provisions above (copy available upon request), and is the patient, the patient's legal representative or is duty authorized as the patient's general agent to execute the above and accept its terms.

_____	_____	_____	_____
SIGNATURE: PATIENT, LEGAL REPRESENTATIVE,AGENT	DATE	RELATIONSHIP IF NOT PATIENT	DOB