BRESSI RANCH
Family Dentistry
Michelle Lee, DDS
6221 Metropolitan Street Ste. 200
Carlsbad, CA 92009
Phone: 760-602-9500
Fax: 760-602-9510

Financial Agreement

Bressi Ranch Family Dentistry is committed to providing you with the best dental health care available. We have provided a clear understanding of our office financial policies to relieve some of the anxiety associated with going to the dentist. We want to be certain that our policies are clear and that all of your questions are answered to your satisfaction. For your convenience we honor several different payment plans.

Cash or Check

When you do not have dental insurance, we ask that you pay in full for your dental services at the time of each appointment. We offer a 10% courtesy for patients who wish to pay for their entire treatment plan by the first appointment.

Credit Cards

We gladly accept MasterCard, Visa, Discover, American Express and Care Credit.

Dental Insurance

As a courtesy to you we will gladly process your insurance claim forms, and will send any necessary x-rays needed. We will make a good faith estimate for planned treatment and request that you pay your estimated portion at the time of service, unless other arrangements are made with our Office Manager. When payment has been received from your insurance carrier(s), we will settle the balance of your account. There may be a difference between the estimated portion and actual payment from your insurance, if so the difference is the patient's responsibility.

We understand insurance guidelines can be hard to understand and overwhelming at times. Your insurance company makes the final determination once treatment is completed and the claim is submitted. If your insurance carrier(s) denies coverage, the entire amount will become due and payable by you. Although we make every effort to help you obtain your full benefit there are many variables we cannot anticipate. **Please be aware that your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility.**

I authorize payment to be made directly to Bressi Ranch Family Dentistry by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance carrier. I hereby agree that in the event of default of any amount due, and if this account is place with a collection agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including any attorney fees and court costs incurred and permitted by laws governing these transactions.

Print Patient Name:_____

Signature: _____ Date: _____
Patient, Parent, Guardian

Relationship to Patient: _____