Seneca Mariano, DDS
Mariano Dental Care
6094 Mowry Avenue
Newark, CA 94560

PATIENT FINANCIAL LIABILITY FORM

Welcome to Mariano Dental Care. We are happy you have joined our dental family. We look forward to providing quality dental care to you, but before we can proceed, we need you to agree to the following terms:

Please understand that full payment of your account is considered part of your treatment and is required for all services rendered. Also, payment for past services rendered and treatment given is required before all future services and treatment may be made. We expect full payment at the time the services are rendered. This office accepts Cash, Visa, Master Card, American Express and Discover Card. Checks are accepted with a valid photo ID, but returned checks are subject to additional service fees. Extended payment plans may be offered with PRIOR credit approval but must be made prior to treatment. All unpaid accounts are sent to collection after payment is not made in a reasonable time period and may adversely affect your credit. You agree to pay all fees incurred in the pursuit of delinquent account balances. Please understand that non-emergency services can be denied for delinquent accounts and collection action may affect your patient status with this practice.

INSURANCE IS ACCEPTED UNDER THE FOLLOWING CONDITIONS: If you have dental insurance we will be happy to complete the necessary forms for your claim as a courtesy to you. All co-payments are due to Mariano Dental Care at the time of services. Patient agrees to pay all deductibles, coinsurance, and services deemed "patient responsibility" as identified by the insurance carrier. Deductibles, coinsurance and patient portions are billed monthly on receipt of the patient's insurance statement from the carrier regarding the patient claim. YOU, the patient, are responsible to render payment once billed for the remainder due for treatment, should there be a balance after the payments made at time of services and the insurance benefit. Claim payments denied by the insurance carrier for any reason become the responsibility of the patient and you agree not to withhold payment from the Practice in the event of a dispute between you and your carrier.

Although we make every effort to obtain accurate information from the insurance carrier, verification of benefits is not a guarantee that an insurance carrier will pay a claim, or pay the amount estimated. Patients are responsible for checking their benefits prior to treatment. The insurance carrier makes final determination, based upon the plan's level of coverage and associated policies, upon receiving the claim. Denied claims become the responsibility of the patient.

In the event that a patient does not have insurance and is paying by cash, we offer a 5% discount off of our billable amount.

I have read the above information and agree to all the terms and conditions contained therein.

_____

Please print name of patient (parent, if minor) or responsible party

_____

Signature of patient (parent, if minor) or responsible party Date

Acknowledgement of Receipt of MARIANO DENTAL CARE Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I,_____ [full name], have received a copy of the MARIANO DENTAL CARE Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)