JONAR R. BONIFACIO, DDS & ASSOCIATES
1620 ALPINE BLVD., SUITE 121, ALPINE, CA 91901
ALPINEDENTISTRY.COM

Financial Policy Form

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage that I may have is based on a contract between my insurance company and me, my spouse, my parent and/or employer. Alpine Dentistry is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. ALPINE DENTISTRY IS ONLY IN-NETWORK WITH CIGNA PPO, GEHA PPO (Select plans), AND UNITED CONCORDIA ELITE PLUS. ALPINE DENTISTRY IS OUT OF NETWORK WITH ALL OTHER PPO PLANS. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to Alpine Dentistry for services, treatments, procedures, and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 60 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance information and any changes thereto.

All returned checks will be subject to a $25 returned check fee. Any account balances that remain unpaid for 90 days from the date of service shall accrue interest of 18% per year and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs of $50.00. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree to be responsible for all costs and reasonable attorney fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company and any agent thereof. For insurance companies that accept an assignment of benefits, I hereby assign to the dentist all the insurance benefits due to me for services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company to make payment directly to the dentist for the costs associated therewith. For insurance companies that do not accept the assignment (i.e. Delta, Blue Shield), I understand that I am responsible for the full charges and my insurance will issue payment directly to the subscriber of the insurance.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office, including email, fax and phone (including landline or cell).

Patient:_____

Print Name:_____

Date:_____

Guardian/Responsible Party:_______________________________________Date:____________