esv
ENDODONTICS
OF SILICON VALLEY

In an effort to comply with FTC Red Flag Rules, prevent identity, theft prevent insurance fraud, & enlist the assistance of a collection agency with delinquent accounts, this office requires all patients or their legal guardians to provide and permit this office to scan & store in their record a copy of a valid driver's license, passport, military ID, or state issued photo ID. As with all patient records, it will be kept in a secure manner.

Allowable Fees

We strive to give the most accurate financial estimates based on the information that your insurance carrier gives to us. It's important that you understand that until we actually receive payment from your insurance company, we can only provide an **estimate** of your share of the costs.
Many insurance carriers base their payments on what they call an "allowable fee" rather than what the office actually charges for that procedure. Many Insurance plans will not tell us the "allowable fee" leaving us to "guess" the correct amount to collect from the patient. This means even when a plan pays 100% a patient can still be left with a balance to pay out of their pocket.

Explanation of Benefits

Please be sure to review your "Explanation of Benefits" that should be sent to you by your insurance company within 3-4 weeks after your appointment. This will show you the amount we have billed, your insurance company's "allowable fees", the amount they paid and your expected patient responsibility. If the amount listed as patient responsibility is more than we collected from you, you can expect to receive a statement for the difference in the near future. If there is something you do not understand, we encourage you to call right away and we will be happy to assist you in understanding your billing statements or your insurance correspondence.

Assignment of Benefits for Treatment Provided by ESV

I assign all dental payments for treatment provided in this office to Micah M. Oller DMD, Inc. D.B.A. Endodontics of Silicon Valley. I understand I am financially responsible for all charges. I understand my estimated patient portion is due at the time of service. Should a balance exist on my account after my insurance has paid I agree to remit payment within 30 days of receiving the first statement. I authorize Endodontics of Silicon Valley to release any dental information to my insurance company. I also understand continued failure to pay any balance owed by me, after receiving written notification, may result in my account being turned over to a third party collection agency.

Missed Appointments

I agree to give 48 hours notice in the event I need to cancel or reschedule an appointment. I understand repeated failure to do so may result in a missed appointment charge of up to **$100.00**. I understand missed appointment charges are not billed to the insurance they are the sole responsibility of the patient.

NSF Payments

In the event a payment made in the form of a check is not honored by my financial institution, I understand I will be charged a **$26.00** fee for each occurrence.

My signature below indicates I have read, understand and agree to all of the above policies. I have also received a copy of this agreement. I wish this agreement to stay in effect until revoked by me in writing.

_____ _____

Patient or Patient's Guardian Date