DR. ELIZABETH PEELING, DMD FICOI
6363 SAN FELIPE, SUITE 200B
HOUSTON, TX 77057
TEL: (346)800-3330
SANFELIPE@UNIVERSITYOAKSDENTAL.COM
Universityoaksdental.com

Cosmetic & Comprehensive Dentistry

NO SURPRISE FINANCIAL POLICY

When being treated for a medical or dental problem, it is easy to forget that a health care office is also a business. We understand that. We also want our patients to understand that an important part of any business is collecting payments for services rendered. In the interest of providing excellent health care and doing good business, we believe it is best to establish a financial policy to avoid any misunderstandings. Therefore, we have developed the following policy

YOU ARE RESPONSIBLE FOR PAYING YOUR BILL

Even if you have medical or dental insurance, remember that your coverage is a contract between you and your insurance company. Please note: We are out of network, for all insurance companies, nor do we have a contractual agreement with any insurance company other than Delta Dental. We are a private, fee for service health care office. We are not a preferred provider nor are we part of a DMO. If we were, we would be obligated to them and not to you, the patient receiving services and care. We refuse to let insurance companies dictate the type and quality of materials and restorations we use.

If your insurance company requests additional information (e.g. chart copies, detailed reports) we will be happy to provide such information. If you are in litigation and your attorney requires copy of records, detailed reports, and consultations (in-office and phone), you will be billed for these services.

WE REQUIRE THAT YOU PAY AT THE TIME OF YOUR TREATMENT VISIT

We accept cash, MasterCard, Visa, Discover and AmericanExpress and CareCredit

For minor patients, the parent/guardian accompanying the minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by cash or credit card.

MISSED APPOINTMENT POLICY

Unless cancelled at least 24 hours in advance, our policy is to charge $45.00 per missed appointment. Please help us serve you better by keeping scheduled appointments or rescheduled at least 24 hours in advance.

I agree to honor the policies outlined above. I agree to make full payment for services rendered on the day of the appointment unless prior arrangements have been made in writing. I agree to pay a $10 monthly billing fee if my account is 30 days past due. I also agree to pay all reasonable attorney's fees and costs of collection incurred if my account is not paid as agreed.

Thank you for understanding our No Surprise Financial Policy. Please let us know if you have any questions or concerns.

Patient/Guardian signature Date

UNIVERSITY OAKS DENTAL

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Assignment of Benefits

Insured name: _____ DOB: _____

Employer: _____

Insurance: _____ Group #: _____ ID/SSN: _____

Insurance phone: _____

This signature on file is my authorization for the release of information necessary to process my claim(s). I hereby authorize payment to University Oaks Dental of benefits.

Signature: _____ Date: _____