Financial Policy

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Thank you for choosing Dr. Michelle Munoz Cruce's office as your dental care provider. We are committed to providing you and your family's treatment. The following is a statement of our Financial Policy. All patients must complete and sign this policy before seeing the doctor. A copy of our Financial Policy will be given to you upon your request.

_____ We accept cash, most major credit cards, and Care Credit. We do not accept personal checks. All balances older than ninety (90) days may be subject to being sent to collections. If so, your account will be charged a fee of an additional $15.00 unless payment arrangements have been made.

_____ There will be a $50.00 charge to your account if our office is not given a 48 hour notice to cancel or reschedule any of your scheduled appointments. We ask that a 48 hour notice is given so that we may provide other patients with their necessary dental care.

_____ Your insurance is a contract between you, your employer and your insurance company. We are not party to that contract. We cannot bill your insurance company unless you give us all of your insurance information.

_____ At the time of service, you will be expected to pay the *estimated* difference between what your insurance covers and the actual charges. Keep in mind that this is only an *estimate*. If your insurance company decides to cover less than the *estimated* portion, decides **not** to cover a service rendered, or **has not paid your account in full within ninety (90) days, the balance will be YOUR responsibility**. Please be aware that some, and perhaps all, of the services provided may be non-covered services and as such, you are responsible for the full amount.

_____ Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

Authorization and Release

I authorize Dr. Michelle Munoz Cruce to release any information, including the diagnosis and records of any treatment or examination rendered to myself or family members during the period of such dental care to third party payers.

I authorize and request my insurance company to pay directly to Dr. Michelle Munoz Cruce the insurance benefits otherwise payable to me. We emphasize that as health care providers, our relationship is with YOU, not your insurance company. While the filing of insurance is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Responsible Party Date