Sarah Baldwin DMD Inc
3645 Grand Avenue Suite #103
Oakland, CA 94610
(510)251-1962

AUTHORIZATION

The information that I have been given on the Dental Registration and History form is correct and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have in the completion of this form. I understand that this information will be used by my dentist to help determine appropriate and healthy dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature _____ Date _____

OFFICE FINANCIAL POLICY

1. **Full payment is due at the time of the service.** This includes Visa, MasterCard, cash, or check. Any returned checks are subject to a return check fee depending on the bank charges.

2. **Regarding Indemnity Insurance**
   We may accept assignment of insurance benefits after your first visit. However, we do require the bill to be paid at the time of the service. The balance is **YOUR** responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are NOT a party to that contract. Please be aware that some, perhaps all, of the services provided may be non-covered services under the Dental Indemnity Plans.

3. **Regarding Insurance plans where we are participating as a provider.**
   All co-pays and deductibles are due at the time of treatment. In the event that your insurance changes to a plan where we are not a participating as a provider, please inform us and refer to the above paragraph.

4. **Usual and Customary Rates**
   Our office is committed to providing the best treatment of our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

5. **Missed Appointments**
   Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at **$50.00 per 30 minutes.**

6. **Overdue Accounts**
   Accounts over 90 days will be assigned to a collection service. A finance charge of 16% per annum on the entire balance will be applied. In addition, a late fee of $65.00 will be added.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

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

_____ _____
Signature of Responsible Party Date