CURTIS L. HOWARD D.D.S.
9950 Campo Rd. Spring Valley 91977
619.463.2097

FINANCIAL POLICY:

For non-insured patients full payment is expected at the time services are rendered, unless prior payment arrangements have been made.

For our insured patients we understand that your insurance may make a payment and we will estimate your portion. Once the insurance has made their payment we will send you a statement for the remaining balance or, if you request, a check for a refund.

Your options for payment include:

- Cash, check, or credit card for the full amount on the day of service.
- 50 % down and the remaining balance paid monthly. (this must be prearranged before starting treatment)
- For larger procedures which will take more than one appointment: 50% down at the first appointment and the remaining 50% at the final appointment.
- Care Credit, a financing option which allows you to spread your payments for up to 18 months interest free, as long as the balance is paid by the end of the promotional period. Care Credit also offers extended payment periods of up to 48 months with low interest rates.

By signing I acknowledge that I have read and understand the financial policy for Curtis L. Howard DDS

SIGNATURE OF RESONSIBLE PARTY:

_____ **DATE** _____/_____/____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records and/or my child's records, to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records and/or my child's records to the following persons who are involved in my care, or my child's care, or payment for that care.

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement I agree to be financially responsible for payment of services not paid by my dental care payer, and attest to the accuracy of the information I have provided.

PATIENT'S OR GUARDIAN'S SIGNATURE:

_____ **DATE**_____/_____/_____

24 hour cancellation policy, $50.00 cancellation charge if after 24 hour period