Our Financial Policy

Thank you for choosing us as your dental specialist. At our office, we strive to deliver the finest surgical care as well as reasonable costs to our patients. Payment is expected at the time the service is rendered. For your convenience we accept Visa, MasterCard, Discover, American Express, checks, cash, and Care Credit.

Currently we participate with the following dental insurance plans: **Delta PPO/Premier, Aetna PPO, and Cigna PPO (includes GEHA Federal plan), and Metlife**. Additionally, Dr. Davary is in-network with **United HealthCare Dental PPO, and Humana Dental PPO**. We are out of network with all other dental or medical insurance plans and have opted out with MEDICARE. Several procedures must be submitted through your medical insurance first and you will receive an explanation of benefits (EOB) from them. To ensure that the dental portion is processed promptly, our office will require that you send us a copy of the EOB.

I understand that my dental and/or medical insurance may not provide coverage for treatment provided by our practice. If desired, your treatment plan can be sent to your insurance to verify if your procedures are covered and the amount of maximum reimbursement.

Our practice is required to impose a 3% surcharge for credit card payments that will not be greater than our cost of acceptance. To avoid this charge we invite you to pay using a debt card, an HSA/FSA card, check, cash, Apple Pay or Google Pay.

I understand that I have read the information above and agree to be financially responsible for all charges incurred during my treatment with Dr. Delgado.

Print Name _____ (name of Guardian if patient is a minor)

Signature _____ Date _____

PATIENT RECORD OF DISCLOSURES

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

ÿ Home Telephone_____ **Written Communication (Email or Post Mail)**

Work Telephone_____ **Cell**_____

OK to leave message with detailed information **Leave call back number only**

Please list any person(s) whom you are authorizing us to disclose information regarding your dental treatment.

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices and have given permission to the above Record of Disclosures.

Please Print Name _____

Signature _____ Date_____