Paying for Your Care

Patient: _____ Date of Birth: _____

Thank you for choosing Pittsburg Family Dental for your dental care. Our goal is to deliver the best and most comprehensive dental care available. An important part of achieving this goal is making the cost of optimal care as manageable for our patients as possible by offering several payment options.

You can pay for your treatment by choosing from the following options:
- Cash
- Personal Check
- Visa or MasterCard
- Care Credit (Allows you to pay over time with no annual fees or pre-payment penalties)

Please be aware that our office requires payment in full at the time of treatment unless otherwise agreed upon. In that case you may be asked to sign a patient payment agreement stating the agreed upon terms. If you have dental insurance we will expect your co-payment at the time of treatment. For treatment that requires multiple appointments, an alternate payment arrangement may be provided.

As a courtesy to our patients with dental insurance, we are happy to work with your carrier to best utilize your benefits and directly bill them for reimbursement for your treatment. We make every effort to keep your insurance information current; however, we are not responsible for any changes made to your insurance plan without our knowledge. Your insurance policy is a contract between you and your insurance carrier, in which your insurance plan is governed by your employer or your individual plan. It is your responsibility as the policy holder to inform us of changes to your plan, to know what your plan does or does not cover and any loss of coverage or additional coverage that you are eligible for.

A $50 fee may be incurred for missed appointments or cancellations without at least 24 hour notice. There is a $25 fee for all returned checks.

Cell Phone: ❑ I consent to the dental practice using my cell phone number to (choose one or both) ❑ call or ❑ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) _____ _____(initial)

Other federal and state rules govern telemarketing and commercial email messages. A summary of these laws is available on the website of the Office of the Attorney General at oag.ca.gov/privacy/privacy-laws. If you have any questions, please do not hesitate to ask.

_____ _____

Patient, Parent or Guardian Signature Date

_____ _____

Patient, Parent or Guardian Name (please print) Date

Relationship to patient