



**Nancy Nehawandian, DDS, FAGD**  
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### **FINANCIAL INFORMATION**

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your services is considered a part of your treatment.

***Payments for services are due at the time services are rendered.*** Your ***estimated*** portion of the fees will be computed at the time of your appointment. We gladly accept VISA, Mastercard, Discover, American Express, checks, or cash. For low monthly payments, we also offer financing through *Capital One, Citibank* and *Care Credit*.

#### ***Regarding Insurance***

Your benefit plan is a contract between you and your insurance company. We are not a party to that contract. Please remember that no insurance company attempts to cover all dental costs. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. Some services provided may be non-covered services and not considered "*reasonable and customary*" under your specific insurance plan. This does not dictate what treatment should be done or change the recommended treatment plan of the doctor; rather it is the limitation of the benefit allowed for that type of procedure. We will make every effort to help you collect the maximum benefits on all claims; however the responsibility for payment will be yours. All co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage changes, it is your responsibility to inform us.

#### ***Usual and Customary Rates***

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 arbitrary determination of usual and customary rates.

A 1.8% rebilling fee will be applied to accounts over 30 days old. If an account becomes delinquent, the guarantor will be responsible for all legal fees incurred in collection of that account. There is a \$25.00 service charge for any returned checks.

I have read the above statements. I fully understand and agree to these terms and conditions.

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Signature of Patient or Responsible Party

Date