# DIAMONDSMILES Financial Policy

Payment is expected the day services are rendered. We will file your insurance claims for you the day of your service. We accept cash, checks, Mastercard, Visa, American Express, and Discover. Care Credit is available to assist you with no-interest, or low interest, financial assistance if needed. Any special assistance needed can be discussed with the business manager in privacy.

**Broken appointments, or cancellations within 24 hours of the appointment, are subject to a $50.00/hour fee for hygiene appointments, and a $100.00/hour fee for Doctor appointments. A third broken appointment, or cancellation within 24 hours, will require a non-refundable prepayment for services to be performed.**

I, the undersigned, hereby authorize Dr. Luna and office personnel to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Luna to make a thorough diagnosis of the patient's dental needs**. I understand, and give permission for Dr. Luna to use the previous mentioned materials for dental purposes in lectures, seminars, and in photo albums**. I also authorize Dr. Luna to perform any and all forms of treatment, medication, and therapy, that may be indicated, and further authorize and consent that Dr. Luna may choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk, such as serious illness or even death, and that I have provided a thorough and honest report of my medical history. I understand that there is no guarantee to the outcome of any services performed.

I understand that responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered. I further understand that a 1 ½ % finance charge (18% annually) will be added to any balance over 30 days. In case of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient________________________________________ Date________________________

Parent or Responsible Party__________________________________________________