Bella Smiles
The Dental Office of Jaime Rojas D.D.S.
78640 Hwy. 111, La Quinta, CA 92253 (760)564-0955 fax (760)564-4826
Email: dentalinfo@bellasmilesdds.com

Patient Name: _____

Financial Policy for the Office of Jaime Rojas, DDS, Inc.

The following is the financial policy for this office:

Uninsured Patients

Payment in full is required for services on the day services are rendered, unless specific arrangements are made in advance prior to the appointment date.

Insured Patients

Whether "in-network" or "out-of-network" we will estimate, as closely as possible your coverage, but until we actually receive the payment from the insurance company, it is just an ***estimate***. Most policies do not cover 100% of the cost of treatment. Because of this, and the delay in receiving payment from the insurance company, your deductible and your portion of the charges are due on the day services are rendered. We will assist you in dealing with your insurance company, but ultimately the responsibility lies with you. If, after 60 days, the insurance company has not paid, the full balance will be due by you.

If you have any questions, feel free to ask them at any time. We wish to be of assistance in any way we can.

_____ _____

Signature **Date**

E-Mail/Text Notification Opt-in Consent Form

Bella Smiles works with Demandforce to offer E-Mail and Text Message notification for Appointment Reminders and other patient care related information. This system will allow you to confirm appointments at a time convenient to you, to request future appointments, and to keep you informed of office and patient care information. If you choose to opt-in to this system please provide us with your email address and text messaging number below. You will receive a welcome email and text allowing you to opt-in and also set your own preferences; you may also opt-out at any time. This information is only used for Bella Smiles purposes and is governed by the same HIPAA protection as all other information; we will not sell/share your information with any unrelated 3rd parties.

E-Mail: _____ Text Number: _____

I authorize Bella Smiles to notify me of patient care related information on my

E-Mail Text Messaging (Please check those that apply).

Signature: _____ Date: _____