Bobby Jivnani, D.D.S.
670 West Campbell Rd., Suite 120
Richardson, Texas 75080
(972) 690-1235

FINANCIAL POLICY

Thank you for choosing Dr. Bobby Jivnani as your dental care provider. We are committed to providing you with the highest quality of dental care utilizing only the best materials and education available. Anything we say or do will be centered on this philosophy. We are committed to your treatment being successful, and payment of your bill is considered part of that treatment. The following is our financial policy, which we ask you read, initial, and sign prior to treatment.

_____**PAYMENT FOR SERVICES RENDERED**: Patients are responsible for payment of all services rendered on their behalf or their dependents. Payment is due at the time of service unless other financial arrangements have been made in writing in advance. Our office accepts cash, checks, MasterCard, or Visa.

_____**INSURANCE ASSIGNMENT**: We may accept assignment of insurance benefits, however, most insurance plans do not cover 100% percent of the fees charged and have a deductible, which must be satisfied before any insurance benefits can be received. Also, please keep in mind that some, and perhaps all, of the services may not be considered reasonable and necessary under the provisions of your insurance plan. We require that all deductibles, co-pays, and/or any percentage of the bill that the primary insurance carrier does not cover, be paid at the time of the service. Furthermore, any outstanding balance not paid by the primary insurance carrier will be the responsibility of the patient. If the insurance company has not paid your balance in full within 60 days, the balance will automatically be transferred to your account, and you will be responsible for the balance owed. This office cannot render services on the assumption that our fees will be paid by your insurance company. We must emphasize that, as your dental provider, our relationship is with you, our patient, and not your insurance company. Your insurance is a contract between you, your employer, and the insurance company. Our office is not a party to that contract or any possible restrictions.

_____**DEFAULT ON PAYMENT**: In the event I fail to pay for any part of the services rendered, I understand that I will be sent to a collection agency and will be required to pay all collection/legal fees as well as all court costs. And that my collection fees will be added to my principal balance at 35%.

Responsible Party's Signature:_____

Date: _____