Ramin Azghandi, DDS, PA
Periodontics & Implants

Financial Responsibility

As advocates for our patients, we will make every effort to access the maximum benefits allowed under your third party payer contract (insurance). As a patient in this office, you will receive treatment that is specific to the problems that are noted during your initial examination. In return, your financial responsibility for this treatment will be to the doctor. We will assist you in obtaining reimbursement from your third party benefits payer (insurance) for part of this responsibility. If you do not have third party coverage we will gladly discuss other options that are available to you.

It is important that you understand that your benefits contract may have an *allowable amount* for each procedure. This *allowable* is determined by the benefit contract you have with the company and does NOT always equal the doctor's fee. The third party payer may pay a percentage of the *allowable*. You are then responsible to Dr. Ramin Azghandi for payment of the balance. This payment may include your deductible (if not already satisfied), the co-payment, and any remaining portion of the doctor's bill that is not covered (providing we are NOT contracted providers with the benefits payer). The portion estimated to be your responsibility will be due at the time of service.

Many patients have a commonly held misconception that medical and dental benefit policies will pay for their entire treatment. This is incorrect and untrue. Please understand that third party payment is no longer termed "insurance" as it does NOT guarantee payment of benefits. Financial responsibility for services you receive at the office is yours alone.

Again, we want to assure you that we will make every effort to obtain benefits from your third party payer. We gladly process your claim but we request that you pay your estimated portion at the time services are rendered. ***Although we strive to get accurate third party information such information is always an estimate and NOT a guarantee of payment.*** We thank you for your confidence in our office and look forward to providing you with competent care and courteous service.

Name of Responsible Party: _____
Please Print

Relationship to Patient: _____
Please Print (Self, Parent, Lawful Guardian)

_____ _____
Signature *Date*

_____ _____
Witness *Date*