BERNARDO CALDAS
ORTHODONTICS

Financial Policy & Insurance Information

1. PATIENT INFORMATION

Patient Name: _____ Date of Birth: ____ / ____ / _____

Responsible Party: _____ Relationship to Patient: _____

Phone: ( ) _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

2. INSURANCE INFORMATION

Primary Insurance Carrier: _____

Subscriber Name: _____ Member ID: _____

Group Number: _____ Subscriber Date of Birth: ____ / ____ / _____

Employer: _____

Secondary Insurance Carrier (if applicable): _____

Secondary Subscriber Name: _____ Member ID: _____

Group Number: _____ Subscriber Date of Birth: ____ / ____ / _____

Employer: _____

3. FINANCIAL POLICY

- Insurance benefits are a courtesy estimate only and not a guarantee of payment.
- The patient or responsible party is ultimately responsible for all fees, regardless of insurance coverage.
- Co-pays, deductibles, and any remaining balances are due according to our office policy.
- Missed appointment fees and/or returned payment fees may apply.
- Please keep your account balance current throughout the course of treatment.

4. ASSIGNMENT / AUTHORIZATION

I authorize the release of any information, including dental/orthodontic records and treatment information, necessary to process insurance claims. I also authorize payment of insurance benefits directly to Caldas Orthodontics when applicable. I understand that I am responsible for all fees not covered by insurance.

5. SIGNATURE

_____ _____ ____ / ____ / _____

Responsible Party Signature | Printed Name | Date