SMILE PERFECTION
DR SHARAD PANDHI
5828 N Oracle Rd Suite#100
Tucson, AZ 85704
(520)293-2166

FINANCIAL POLICY

Thank you for choosing us for your dental care provider. We are committed to providing the highest quality of dental care available to all of our patients. Our main concern is that you receive the proper and optimal dental treatment needed to restore your health. Please review and sign below so that we can avoid any misunderstandings regarding payment for services rendered.

PAYMENT: Payments and insurance co-payments are due at the time of service. We accept cash, checks, Visa, Mastercard, America Express, and Discover. Credit card payments can be swiped in the office or called in over the phone. You will need to provide all pertinent information as well as the security numbers on the back.

FINANCING: Flexible financing options are available through outside finance companies and are subject to their approval. Please ask our staff for information regarding Chase if interested.

RETURNED CHECKS: Returned checks will be subject to a $25.00 NSF fee as well as any collection and interest fees incurred.

INSURANCE CLAIMS: We file your insurance as a courtesy. Your contract is between you, your insurance company, and your employer. We will do our best to assist you with questions and basic information but it is your responsibility to know your specific insurance plan's frequencies and specifications. All co-pays will be due at the time of service and we reserve the right to transfer any outstanding claim balances over to the patient after 90 days.

MISSED APPOINTMENTS: We ask for 2 working days notice for all schedule changes. Appointments changed with less notice may be subject to a $35.00 fee for hygiene appointments and $50.00 for doctors'.

RESPONSIBILITY FOR PAYMENT: You will be responsible for any and all outstanding balances on your account including any unpaid balances by your insurance company. All balances are due upon receipt.

COPY OF RECORDS: There is a processing fee of $25.00 for all requests for records for the individual or another dental office. A signed release form is also required. This fee will be waived if we are referring you to a specialist.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL PAYMENTS THAT MAY BE DENIED OR OTHERWISE UNPAID BY MY INSURANCE COMPANY.

I AGREE THAT THE PREVAILING PARTY IN ANY ACTIONS BROUGHT TO COLLECT SUMS OWING UNDER THIS AGREEMENT SHALL BE ENTITLED TO RECOVER REASONABLE ATTORNEY FEES AND COLLECTION COST.

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Signature of party responsible for the account Date