

**Cosmetic Dentistry of San Antonio**  
**Dr. Edward J Camacho, D.D.S.**

**Office Policies**

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact people have different needs in fulfilling their financial obligations, we are providing the following payment options. ***Please note that payment is due at the time of service.***

**Payment Policy:**

- *Cash, Check, Visa, MasterCard, American Express and Discover are accepted.*
- **For any treatment over \$250, payment will be due prior to scheduling your appointment.**
- *Flexible Payment Options: if extensive treatment is required and you wish to extend your payments, we can arrange low monthly payments with approved credit through CareCredit or Chase Health Advance.*
- *Our staff has been instructed to collect payment upon arrival for your appointment if payment for services has not already been received.*

**Insurance Policy:**

We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, **we can make no guarantee of any estimated coverage.** Because your insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. If your insurance company does not pay their estimated benefits within 30 days from the date of service, **you are responsible for the entire treatment fee.**

***\*Please be advised Dr. Camacho is not an in network provider of insurance.\****

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**Cancellation Policy:**

Our goal is to provide you with quality dental care and personal attention. Your appointment time is reserved *just for you*. If you cannot keep your appointment, please provide at least 48 hours notice for treatment appointments and at least 24 hours notice for cleaning appointments in order to avoid a \$25 cancellation fee.

**Informed Consent for X-rays & Photographs:**

I understand that photographs, x-rays, and other records may be made during the course of my examination, treatment, and follow-up care. I give permission for these services to be rendered. There is a \$25 x-ray duplication/transfer fee.

**Release of Dental Records Policy:**

**To the insurance company:** (If Applicable)

I authorize Cosmetic Dentistry of San Antonio to release any dental records to my insurance company upon request, including, but not limited to, periodontal charting, radiographs, and diagnostic photos.

**Returned Check/Collections Policy:**

A \$50.00 fee will be assessed for all returned checks. Delinquent accounts will be assessed a \$15 collection fee.

**Acknowledgement:**

I hereby acknowledge and agree to the above office policies. I also have received a copy of the Notice of Privacy Practices of this office. Please note: it is your right to refuse to sign the acknowledgement.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Responsible Party

\_\_\_\_\_  
CDSA Staff