Official Office Policies of

Jayashree Srinivasan DMD, LLC

Finance Policy

All patients need to understand that all services provided are charged directly to the patient and that he/she is responsible for any charges related thereto. As a courtesy to you, our office will file your insurance claim on your behalf. Please note, however, we cannot render services under the assumption that charges will be covered by your insurance company. We strive to provide the best dental treatment according to the patient's needs regardless of insurance coverage. Patient co-payments are determined by each individual insurance policy and are due at the time services are rendered. When insurance has finalized, a statement will be sent with the balance due. Any unpaid balance older than thirty (30) days, will incur a finance charge of two percent (2%) per month.

Initial_____

Appointment Policy

To provide better time management and as a courtesy to the staff as well as other patients, please note that our office requests at least forty-eight (48) hours notice for all appointment cancellations. While it is understood that emergencies are an exception to said rule, broken appointments and/or appointments cancelled with less than the requisite notice are subject to a fee of twenty-five dollars ($25.00) for hygiene appointments and fifty dollars ($50.00) for doctor appointments. Also, patients who arrive more than ten (10) minutes late for their scheduled appointment may be rescheduled and/or charged fee of twenty-five dollars ($25.00). Please note that the aforementioned fees will be charged to your account and not to your insurance company. Late fees will need to be collected before your next appointment can be scheduled.

Three (3) broken and/or late cancelled appointments can be a reason for dismissal.

Initial_____

General Policies

-All cellular devices are to be turned off during treatment to better serve your dental needs.

-We strive to provide you with the best comprehensive dental care. In order to do that, we request you have any recent radiographs sent to our office before your scheduled dental

appointment. This allows us to review your radiographs and determine if additional ones will be needed on the day of your appointment.

-A fee of thirty-five dollars ($35.00) will be charged for returned checks.

Initial_____

I hereby attest that I have read and understood the foregoing "Official Office Policies." I hereby unconditionally guarantee payment for dental services rendered to the patient listed below to include any, and all, future services, as well as those presently contemplated. I hereby authorize payment of all benefits directly to Jayashree Srinivasan, DMD, LLC. I have read and fully understand that all dental charges incurred by me, or my dependents, for services rendered by Jayashree Srinivasan, DMD, LLC are solely my financial responsibility.

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (up to thirty-three and one third percent (33.33%)), attorney fees and/or court costs, if such be necessary.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:

The undersigned hereby agrees that, in order for our office to service your account or to collect monies you may owe, Jayashree Srinivasan, DMD, LLC, and/or any agents thereof, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages and/or emails, using any email address provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Jayashree Srinivasan, DMD, LLC, its employees and/or agents may contact me/us as above described

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Print Responsible Party Name

_____ _____

Signature of Responsible Party or Legal Representative Date

Acknowledgment of Notice of Health Information Privacy Practices

I hereby acknowledge that I have read a copy of the "Notice of Health Information Privacy Practices" adopted by Jayashree Srinivasan, DMD, LLC.

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Signature of Patient or Legal Representative Date