Emily Zaramella, DDS, PLLC
901 S. Mopac, Bldg. 2 Suite 395
Austin, TX 78746-5776
512-328-4411

FINANCIAL INFORMATION

Thank you for choosing us as your dental healthcare provider. We will deliver treatment in a timely manner and at a reasonable fee. We are also committed to providing you with all the information that you need in order to make an informed decision regarding your treatment.

We do realize financial concerns are unavoidable, so we offer a number of financial options. We want you to be able to enjoy the benefits of dental health. We gladly accept cash, checks, Visa, MasterCard, Discover and American Express.

We will gladly assist you in filing your dental insurance. It is important, however, that you are aware of the following information:

- Your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. In order to file and estimate your benefits, it is imperative that you provide us with the most recent necessary information. This includes: claims address, telephone numbers, group/policy numbers, and benefit information.
- As a courtesy to you, we will file your primary insurance claims. We do not file your secondary insurance.
- We are not a preferred provider and therefore do not have negotiated rates with your insurance.
- You, not the insurance company, are responsible for all of our fees.
- If your insurance company does not pay your claim within 60 days from the date of service, we will require that you pay the balance in full and have your insurance company reimburse you directly.
- For our patients with insurance, we will provide you with an estimate of benefits that the insurance company is expected to pay. Your portion is expected at the time treatment is rendered.

Because your time is important, it is our commitment to see you promptly. Your appointment is scheduled just for you and any change in your appointment affects many people. We appreciate your timely arrival. Please understand that emergencies do occur and in these situations we will do everything we can to see you at your appointed time.

In the event that missed appointments occur on a regular basis, we reserve the right to assess a fee to your account.

In the event that your account is turned over to a collections agency, you are responsible for the balance, any finance charges, as well as all collections and attorney's fees.

I have read and understand the above information.

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____
* If patient is not 18 years old

If you would like a copy of this agreement for you records, let us know. We are happy to provide a copy to you.