Krishna Neelagiri, DDS

Financial and Scheduling Policy

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: Cash, Check, Credit Card (Master Card & Visa), Care Credit. A finance charge will be applied for outstanding balances 30 days or older at a rate of 1.5% per month. Returned checks will be charged a $35 fee. Accounts sent to collections will be charged a $35.00.

Scheduling of Appointments: If you need to change a scheduled appointment, we ask that you give us 48 hours' notice so that we can make this time available to others. If we do not receive the full notice as requested, and we are NOT able to fill your scheduled appointment time with another patient, you will be charged $50.00. This fee will need to be paid before another appointment will be scheduled for you.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. _____(initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____ (initial)

I have read the above and agree to the financial and scheduling terms. _____(initial)

Minor/Child Consent

I, being the parent or guardian of _____do hereby request and
Name of minor child
authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Patient/Parent Name (Print) _____Date _____

Patient/Parent Signature _____Date _____

Krishna Neelagiri, DDS • 536 Estudillo Avenue, San Leandro, CA 94577
P: 510-483-2244 • F: 510-483-0825 • E: clovedentalsl@gmail.com • www.clovedentalcares.com