INSURANCE INFORMATION

YOU WILL BE GIVEN AN "ESTIMATED" PORTION FOR YOUR DENTAL TREATMENT THAT IS NEEDED, THIS IS ONLY AN ESTIMATE. SOME TEETH MAY HAVE HIDDEN DECAY, OR AFFECTED NERVES, REQUIREING MORE EXTENSIVE DENTAL TREATMENT AND ADDITIONAL COST. PAYMENT IS DUE AT THE TIME OF SERVICE, WE WILL ASSIST OUR PATIENTS WHO HAVE INSURANCE BY FILING THE NECESSARY FORMS. PLEASE BE ADVISED YOUR INSURANCE COMPANY WILL PAY A PERCENTAGE OF OUR FEES AS DETERMINED BY YOUR INSURANCE COMPANY (REFERRED TO AS USUAL, CUSTOMARY, AND REASONABLE FEES), NOT NECESSARILY THE ACTUAL FEE CHARGED BY DR. CASTRO. YOU WILL BE RESPONSIBLE FOR THE DIFFERENCE BETWEEN DR. CASTRO'S FEES AND THE FEE "SUGGESTED" BY YOUR INSURANCE COMPANY, SHOULD THERE BE ONE.

DR. CASTRO IS ONLY A LISTED PROVIDER FOR SOME OF THE FOLLOWING INSURANCE PLANS UNDER DELTA (we are no longer accepting new patients with Delta Insurance), BLUE CROSS, AND GUARDIAN. OTHER INSURANCES WHERE YOU HAVE THE "FREEDOM OF CHOICE" WE WOULD GLADLY SEE YOU AND BILL YOUR INSURANCE. AS WITH ANY INSURANCE PLAN WE CAN NEVER GUARANTEE EXACT PAYMENT. ULTAMETLY YOU ARE RESPONSIBLE FOR ANY UNPAID BALANCE AFTER YOUR INSURANCE PAYMENT HAS BEEN RECEIVED BASED ON OUR FEE, NOT NECESSARILY THE AMOUNT PAID BY YOUR INSURANCE.**

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I HEREBY GIVE AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS (AS LONG AS I AM A PATIENT OF RECORD) BE MADE DIRECTLY TO DANIEL CASTRO, DDS FOR DENTAL SERVICES RENDEDED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE. IF FOR SOME REASON MY ACCOUNT SHOULD BECOME DELINQUENT (AFTER 30 DAYS) I AGREE TO PAY THE INTEREST CHARGES OF 18% ON THE UNPAID BALANCE. OUR OFFICE FILES YOUR INSURANCE AS A COURTESY TO ALL OUR PATIENTS AT NO CHARGE. IF AFTER 30 DAYS WE ARE UNABLE TO COLLECT FROM THEM IT WILL BE YOUR RESPONSIBILITY TO CORRESPOND WITH YOUR INSURANCE COMPANY IN AN ATTEMPT OF PAYMENT. IN THE EVENT OF DEFAULT, I AGREE TO PAY ALL COSTS OF COLLECTION, AND REASONABLE ATTORNEY'S FEES. I HEREBY AUTHORIZE MY DENTAL CARE PROVIDER TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

SIGNATURE ______________________

DATE ______________________

DANIEL CASTRO, DDS 965 NORTH RESLER, SUITE 105 EL PASO, TEXAS 79912