Henry D. Espinosa Jr., DDS
7611 Indian School Rd NE, Suite 202
Albuquerque, NM 87110

FINANCIAL POLICY

Active Therapy Procedures (Root Planing/Scaling and Surgical Procedures) & Maintenance Procedures and Exams

If you have insurance:

We do accept assignment of insurance benefits for many of the major dental insurances. If we don't accept assignment of your insurance we will file it for you and they will reimburse you directly.

We are able to give you an estimate, **not a guarantee** of what your insurance company will pay.

On the day of your appointment, you will be responsible for payment of the charges not covered by insurance, including co-payments and deductibles.

Our goal is to make quality dental care affordable for you!

To reserve your appointment, financial arrangements must be made at the time of scheduling.

Option 1- Pay as you go

We accept all major credit cards and checks (Visa, MasterCard, Discover, and Amex)

Option 2- Financing

Citi Health Card or Springstone Patient Financing – (subject to approval).
6, 12, and 18 month No Interest Payment Plan
24, 36, 48, and 60 month Extended Plans, as low as 7.99% APR ($2000 minimum purchase required)

"Cancelled and Failed Appointment Policy"

Please be aware that we require a **48 hour** working day notice for any cancelations. We would appreciate at least a week's notice, if possible. We do this in order to keep our providers booked so that we may keep our costs low. Last minute cancellations are almost impossible to fill and result in higher prices for everyone.

I understand and agree that, regardless of my insurance coverage, I am ultimately responsible for payment on my account balance. I authorize insurance payment directly to Dr. Henry Espinosa, as indicated on the insurance claim form with "Signature on file". I have read, understand and agree to comply with the financial policies of this office.

Signature:_____ Date:_____

Release of Clinical Information

I authorize release of my medical records as requested by my insurance company for service payment consideration. I also authorize release of information to my general dentist or any specialists involved in my case to ensure collaborative, comprehensive care. In addition, my records may be released to any individual upon my verbal direction.

Signature:_____ Date:_____