DAG ZAPATERO, D.D.S., M.A.G.D.

General | Cosmetic | Restorative | Implant | Geriatric Dental Care

REGARDING PATIENT DENTAL OR MEDICAL INSURANCE

As a courtesy to our patients, we electronically file dental claims for treatment provided in this office. Each claim includes a description of the services rendered, the date of service, and the charges.

Although we provide this filing service, **payment remains the patient's ultimate responsibility**. We will follow up on unpaid claims; however, we accept no liability for lack of coverage, benefit amounts, delays, or denials by any insurance carrier. As the policyholder, you have the right to contact your insurance company regarding payment delays or amounts paid. We are happy to assist you in any reasonable way. Please direct insurance questions to our Insurance Coordinator.

Electronic Billing & Payment Options

For your convenience, we offer electronic billing via email and a secure Text-to-Pay option. Statements and payment links may be sent to the email address and/or mobile number you provide. You may pay balances online through the secure link at any time. Please keep your contact information current so we can deliver these notices promptly.

WE ELECTRONICALLY FILE ALL NON-HMO INSURANCE PLANS.
WE DO NOT PARTICIPATE WITH ANY INSURANCE PLANS.

AGREEMENT FOR PAYMENT FOR DENTAL TREATMENT

If this account is referred to an attorney for collection, the undersigned agrees to pay all collection costs, including attorney's fees of thirty-three and one-third percent (33⅓%) of the principal amount due when turned over for collection, plus interest at the rate of one and one-half percent (1½%) per month (18% per annum) or the maximum rate permitted by Virginia law, whichever is less, on the unpaid balance from the date services were last rendered.

In the event this matter is turned over for collection, I expressly authorize my current employer(s) to provide verification of my employment to this office or its collections attorney.

DENTAL INSURANCE REGISTRATION
AUTHORIZATION FOR SIGNATURE ON FILE / ASSIGNMENT OF BENEFITS

Patient Name: _____ Date of Birth: _____

I, _____, hereby authorize the office of Dag Zapatero, D.D.S. to attach my name to any and all claims or documents related to health benefits due me and my dependents.

I hereby assign and authorize payment of dental benefits otherwise payable to me directly to the office of Dag Zapatero, D.D.S. This Signature on File authorization is valid from the date signed until revoked in writing by me. A photocopy of this document may be used as an original.

I understand that I remain financially responsible for any balance not paid by my insurance carrier. I agree to notify this office promptly of any changes in employment or insurance coverage, and I consent to all policies described on this page.

_____ _____ _____

Signature of Insured / Responsible Party Witnessed by Date