Financial Policy

Dr. Mehrali's Financial Policy

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and education tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and the insurance company. Our office is not a party to that contract.

As a courtesy to you, we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must bring your insurance card at your first appointment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard or Visa.

Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Additionally, our office will charge you $50.00 for broken appointments and appointments cancelled without 24-hour advance notice.

Print Name: _____

Patient's Signature: _____ Date: _____

Mark C. Mehrali, DDS

For more information please contact us today.

2438 N Ponderosa Dr # C200, Camarillo, CA 93010 | (805) 987-6991

Patient Information

Date _____

Patient Information *(Confidential Information)*

Patient's full name | Birthdate | Social Security | Drivers License

E-mail address | Cell phone | Home phone

Current address | City | State | Zip Code

Spouse's Name | Whom may we thank for this referral?

Financial Information

Insured patient's full name | Relationship to patient

Current address | City | State | Zip Code

Is this person currently a patient at this office? Yes | No | Social Security | Work phone

Insurance Information

Insured patient's full name | Birthdate | Social Security | Drivers License

Relationship to patient | Work phone | Home phone

Insurance company name | Group of union name | Group or local number

Employer name | Employer full address

How much is your deductible? | How much have you satisfied? | If patient is a student, list school /college

Do you have other dental coverage? _____ Yes _____ No (If yes, complete the following).

Insured patient's full name | Birthdate

Social Security | Relationship to patient | Work phone

Insurance company name | Group of union name | Group or local number

Employer name | Employer full address

How much is your deductible? | How much have you satisfied?

For All Patients

I hereby authorize the doctor to perform any and all forms of treatment, medications and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

Signature of responsible party | Relationship | Date