Muir Family Dentistry
Stephen C. Francis, DDS & Associates

1124 Arnold Dr. Suite 201
Martinez, CA 94553
925-372-4747

Patient's Name _____

Financial Acknowledgements and Authorizations

I agree that whether or not I am covered by an insurance plan, that I am responsible for payment of all services rendered. If I have insurance, it is my responsibility to know the limitations of the insurance plan that I am using for services at this office. In addition, I acknowledge that I need to give my current insurance information to this office prior to my appointment in order for the office to request payment directly from my insurance company. I assign directly to Dr. Francis, all insurance benefits otherwise payable to me, and I give permission to release all information necessary to secure payment.

I agree that it is my responsibility to know when my appointments are scheduled. It is not the office's responsibility to confirm my appointment. Cancellations and/or missed appointments with less than 24 hour notice may be charged to my account at $35 per half hour of reserved appointment time.

Notice of Privacy Practices and Dental Materials Fact Sheet

I have been offered a copy of the Notice of Privacy Practices as well as a copy of the Dental Materials Fact Sheet.

_____ _____ _____

Signature Relationship to Patient Date