



WELCOME TO OUR PRACTICE

Our mission is to deliver the finest, most cost effective dental health care treatment available today. Following your appointment, Dr. Bialecki will advise you of the necessary treatment to improve and maintain your dental health.

Member:

American
Dental Association

California
Dental Association

Academy For
Sports Dentistry

**Modern
Dentistry for
the smile of
your dreams:**

Ultrasonic
cleanings

Natural looking
crowns & bridges

Tooth whitening

Non-surgical
gum care

Mercury-free
fillings

Porcelain veneers

Dental implants
& restorations

**For your
convenience:**

Major credit cards
& Care Credit™

Lunchtime
appointments

Nitrous oxide
sedation

UNDERSTANDING YOUR TREATMENT AND FINANCIAL RESPONSIBILITY

Our front office staff will discuss with you the cost of today's and future treatments. A treatment plan will be prepared for you detailing your necessary dental care and its cost. **Payment is due when services are rendered unless prior arrangements have been made.** We are sensitive to the fact that some patients may not be able to pay cash for their treatment; therefore, we do offer several alternative payment programs for your convenience. However, any balance remaining after 30 days will be subject to a 1.5% monthly finance charge (APR=18%)

1. Cash or Check
2. MasterCard, Visa, American Express, Discover
3. Auto Debit Plans using a credit card or checking account
4. "Care Credit" Monthly Payment Plan: Unlike other credit cards, there is no annual fee. Upon credit approval, special no-interest plans for 6 or 12 months are available.

APPOINTMENT TIMES ARE RESERVED ESPECIALLY FOR YOU

No charge will be made for rescheduling your appointment provided a 48 hour notice is given, so that the time reserved for you may be made available for other patients. **Failed appointments or late notice cancellations are subject to a minimum \$50 charge and may result in billing for the entire cost of the scheduled care for that day.**

REGARDING DENTAL INSURANCE

If you have insurance, we will help you receive maximum benefits. **We will ask you to pay any deductible, estimated patient share or non-covered services at the time of the treatment** by one of the payment options offered above. **INSURANCE COVERAGE IS ESTIMATED-YOUR ACTUAL INDEMNITY MAY BE MORE. YOU THE PATIENT, ARE RESPONSIBLE FOR ALL AMOUNTS NOT COVERED BY YOUR INSURANCE CARRIER.**

I have read the above financial information and understand my responsibility as a patient in this office.

Signature of Patient/Responsible Party

Date

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