dental office
Ruben Mendez DDS

68100 Ramon Rd suite #A-4 Cathedral City CA, 92234
Tel: (760)483-3344 Fax:(760)266-5133

Office Financial Policy

Dear Patient,

We are delighted to welcome you to our practice and are pleased that you choose us to serve your dental needs. We are serious about providing superior dental care at a reasonable price and proud of our dedication to our patients. Our goal is to help you feel and look you're very best though excellent dental care. A patient may discontinue treatment and ask for a refund at any time except for treatment that has already been rendered. Refunds will be made in the same manner as the original payment except cash payments; they will be refunded in a check. There is a six month grace period for any refund request, after the grace period has been met, no refund will be issued it is the patient's responsibility to request refund. **All Procedures involving lab work are not refundable**. All procedures involving lab work will require a 50% down payment and the remaining balance will be due as treatment progresses, the balance must be paid before final insertion.

Patients WITH Insurance Coverage

Please understand your insurance policy is a contract between you and your insurance company. We are not a party to that contract However, we will be glad to help you obtain appropriate benefits from your insurance carrier as a courtesy to you. **Please note that you are responsible for all co-pays and deductibles at the time treatment is rendered**. We can submit a pre-authorization of benefits from your insurance upon request. Routine treatment (Preventative and basic procedures) are generally performed without submitting any approval.

Patient WITHOUT Insurance Coverage

Patients without coverage are required to pay for services as rendered. We accept Cash, MasterCard, Visa, Discover, or Debit/ATM cards. We also arrange pre-payments and financing plans with Care credit.

Cancellation Policy

We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you .We respect your time and make every effort to keep you from waiting. Therefore, we ask our patients to please give us **a 24 hour notice** if you need to reschedule your appointment. If the schedule appointment is not cancelled within 24 hours there will be a charge of $25. Patients with insurance will charged based on the insurance fee schedule.

x _____ Date:_____

Signature of patient /parent or guardian (if minor)