Patient Label
For Office Use Only

Sycuan Medical Dental Center
Tel: (619) 445-0707
Website: https://www.sycuanmedicaldentalcenter.org

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Sycuan Medical Dental Center as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

1. PATIENT'S FINANCIAL RESPONSIBILITY

- The patient, or the patient's guardian, is ultimately responsible for the payment for treatment and care.
- Sycuan Medical Dental Center will bill your insurance. However, the patient is required to provide the most correct and updated information regarding their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients, or the patient's guardian, are responsible for payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan.
- Co-pays are due at the time of service.
- Co-insurance and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
  - ✓ Charge for returned checks
  - ✓ Charge for missed appointments without 24-hour notice
  - ✓ Charge for replacement of COVID-19 vaccination Card
  - ✓ Late fees for patient balances over 30 days from receipt of billing

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2. PATIENT'S AUTHORIZATION

- I hereby authorize and direct payment of my dental and/or medical benefits to Sycuan Medical Dental Center on my behalf for any services furnished to me by the providers.
- I hereby authorize Sycuan Medical Dental Center to release my insurer, governmental agencies, or any other entity financially responsible for my dental and/or medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such dental and/or medical services as well as information required for precertification, authorization or referral to other providers.
- I hereby authorize Sycuan Medical Dental Center personnel to communicate by mail, answering machine message, and/or email according to the information I have provided in my patient registration information, and ensure that all information provided is the most correct and updated information.

By my signature below, I have read, understand, and agree to all provisions of this Patient Financial Responsibility Form.

Patient's Printed Name: _____

Patient or Representative Signature: _____ Date: _____

If signed by someone other than the patient, please specify the relationship to the patient:

_____