

James A. Pasternak, DDS, Inc.  
21000 Devonshire Street, Suite 209  
Chatsworth, CA 91311  
818-998-1851

Dear Patient:

Since we are responsible for your well-being, we would like to give you some information regarding insurance coverage. There are many different insurance companies and within each company, many different plans, and within each plan different levels of coverage. Since there is such variety, it would be wise for you to check your specific policy so that you will be aware of exactly what coverage you have.

It has been our experience that people are often surprised when they learn exactly what their coverage really is. Sometimes certain services are not covered and payment is denied by the insurance company. In most instances, your personal financial responsibility will include payment of your deductible, co-pay, and any other amount specified by your insurance company. We expect full payment of such amounts immediately upon receiving your statement.

Our fees will be disclosed to you at the beginning of our relationship, if you request it. Should you continue under our care, we will assume that you are informed and agree to pay the fee for our services. We believe that our fees are reasonable for the level of care, expertise and responsibility that we provide to you. We do not and cannot determine our fee schedule based on the myriad number of insurance companies or their varying levels of coverage. Further, we do not want to be involved in disputes between you and your insurance company. By continuing as our patient, you agree to pay our fee, even though your insurance company may not cover it completely or at all.

We are happy to help prepare your insurance form for you, but your portion is expected from you when services are rendered. It is your responsibility to have correct current insurance information available for our office at the time of your visit or procedure. If you do not have a current insurance card or proof of your eligibility with you at the time of your visit, you will need to pay in full for services rendered to you at that time. If insurance information is subsequently provided and results in payment from the insurance company, your payment will be refunded to you. If incorrect insurance information is presented by you to our office, there will be a ten dollar (\$10.00) charge for rebilling your insurance company with the corrected information. If your insurance company requests any additional forms or information from you in order to process your claim, we expect that you will comply as quickly as possible.

\_\_\_\_\_  
*Patient signature* Date \_\_\_\_\_

\_\_\_\_\_  
*Printed name of patient*