Patient Name: _____

Better Living through Dentistry
Kew Gardens, New York

FINANCIAL POLICY & AGREEMENT

Thank you for allowing us to be your dental care provider. We are committed to providing the highest quality of dental care to all of our patients. The prompt payment of your treatment fees allows us to continue providing the highest quality of care. In the pursuit of these goals, we have established the following financial policy:

ESTIMATES We will give you a cost estimate before treatment is rendered. We will try to insure that the cost estimate is complete and accurate, however there are circumstances when it becomes impossible to know exactly what treatment needs to be performed. Sometimes the dental condition requires less treatment, in which case your treatment fees will be less than estimated. Other times, the dental condition requires more treatment than initially anticipated, in which case your treatment fees will be more than estimated. If more treatment is required than initially estimated, you will be informed of the treatment required and fees before the additional treatment is performed.

PAYMENT DUE Full payment of the fees are due at the time of service. We accept cash, check (drawn on a local bank), VISA, Mastercard and Discover. Treatment which requires more than two hours of appointment time will require payment in full five business days prior to the appointment. Appointments will automatically be cancelled if payment is not received.

PAYMENT PLANS Payment plans are available only through CareCredit. Interest free plans are available to qualified individuals. CareCredit and NOT this office determines who may qualify and the amount of credit available.

BROKEN APPOINTMENTS We require 24 hours notice to cancel or reschedule an appointment. There will be a $100 fee assessed for failure to provide 24 hours notice to cancel or reschedule an appointment.

AFTER-HOUR EMERGENCY CARE We provide after-hours emergency care for established patients only. There will be a fee charged for after-hours care.

INSURANCE If we do not participate in your dental insurance plan, you still may receive benefits payable by your dental insurance company. You will be required to pay for treatment in full. We will file your insurance claim for you, assigning benefits directly to you. Your insurance company will reimburse you according to their own fee schedules and restrictions. We regularly monitor the usual and customary fees for our area and insure that we are within this range. The insurance company's "usual and customary fees" are NOT based upon the current fees being charged in a particular area.

If we are a participating provider for your dental insurance, we will file your insurance claim for you. We will estimate your insurance benefit and you will be required to pay the estimated balance at the time of treatment. Since the insurance benefit is an estimate only, you will be required to pay any amount still due after your insurance company pays on the claim. If there is a credit on your account after the insurance payment, this amount will be refunded to you or remain as a credit on your account for future treatment, as your choice. The **OFFICE INSURANCE POLICY AND ASSIGNMENT OF BENEFITS** is made a part of this **Financial Policy & Agreement**.

COLLECTION OF PAST DUE ACCOUNTS Accounts that are not paid according to this **Financial Policy & Agreement** may be turned over to an independant collection agency. In the event that your account is turned over for collection, you will be responsible for all fees incurred in the collection of your account.

RETURNED CHECKS Any checks returned due to insufficient funds must be paid within five business days and will incur a $25 returned check fee. Returned checks not paid in full (including the returned check fee) within five days will incur a 1.5% per month interest charge and the account may be turned over for collection. Any checks returned for being written on a closed account will be forwarded to the State Attorney and the account immediately sent to collection.

I, _____ have read, understand, and agree to abide by this **Financial Policy & Agreement.**

(Print Name of Responsible Party)

☞ Responsible Party Signature _____ Date _____

Relationship to Patient _____