FAMILY DENTAL CARE
2 RUSSELL PLACE
DOBBS FERRY, NY 10522

FINANCIAL POLICY

Thank you for selecting us as your personal dental care team. To promote a long-term, mutually satisfying relationship, we would like to explain our office policy regarding treatment, insurance, appointments and fees. Please read this carefully and ask any questions or bring up any concerns you may have **BEFORE** treatment is rendered. **SUBMISSION TO TREATMENT IMPLIES YOU CONSENT TO TERMS OF THIS AGREEMENT.**

TREATMENT: You will find our entire office staff is dedicated to helping you improve your dental health as efficiently as possible. Every effort will be made to make your appointment as comfortable and pleasant as possible. Please feel free to discuss your treatment with the doctor at any time.

INSURANCE: Even if our office is able to accept direct insurance assignment, the patient or responsible party is still **FULLY REPONSIBLE** for the charges for the treatment rendered. Your insurance **MAY NOT COVER** the services or may only **PARTIALLY** cover them and any **ESTIMATE** given by this office is considered a **GUIDELINE** until insurance payment is received and the patient's account is reconciled. The office can make NO **GUARANTEE** of the actual payment by your insurance company.

MISSED APPOINTMENTS: When we schedule your appointment, the time is reserved exclusively for you. When you fail to notify us of your inability to keep the appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us at least 24 hours notice when you realize that you cannot keep your appointment. When the requested notice is not given , A fee of $50.00 per half hour scheduled will be charged. For those whose schedules make it difficult to effectively plan ahead, we ask that you do not schedule an appointment in advance, but rather call us the day you can come in and we will be happy to see you then-provided the time is available.

PAYMENT IS DUE AT THE TIME OF SERVICE: We accept cash, personal checks, Mastercard, Visa, Discover and American Express. In addition, we offer Care Credit and Citihealthcard for those requiring extended payment plans. When insurance applies we will collect any deductible and estimated co-payment at the time of service. We have payment options available for patients needing extensive dental work. Payment arrangements must be approved before services are rendered. Please see the receptionist for more information.

PROSTHETICS: Crown, Dentures, Bridges, Etc. **FAILURE BY PATIENT TO RETURN FOR THE DELIVERY OF THESE ITEMS IS SUBJECT TO DOCTOR TIME AND LAB FEES FOR TREATMENT PERFORMED.**_____ Initials

SERVICE CHARGES:

1. **MONTHY BILLING:** A 1.5% charge will be applied every month to accounts with balances outstanding 60 days or longer.
2. **RETURNED CHECKS** will result in a $25 fee charged to your account. Replacement of funds must be paid by cash or credit card.
3. **COLLECTION FEES** incurred to collect unpaid balances as a result of failure to conform to the terms of this agreement are the responsibility of the patient or responsible party

Signature:_____ Date:_____
Patient/Parent or Legal Guardian if patient is a minor