



**Finance**

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment:

**Cash      Personal Check      Credit Card      CITI Health Card**

We also participate with various insurance plans. Our staff will ensure that you are provided with a clear explanation so that you may choose the option that best suits your needs.

**Insurance**

Our office is committed to helping you maximize your insurance benefits. We will submit all insurance claims for you. Because insurance policies vary greatly, we can only estimate your portion, but cannot guarantee coverage due to the complexities of insurance policies. As a courtesy to our patients, we will bill your insurance company for treatment rendered. Insurance companies generally make payment in a timely manner. If you ever have any questions, one of our courteous team members is always available to assist you.

***Authorization, Release & Agreement to Pay for Services Rendered***

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

***Office Policies***

- There is a \$50.00 charge for a missed appointment without a 48 hour notice. This fee will not be covered by the insurance.
- There is a fee of \$30.00 for returned checks.
- In the event in which a collection agency is required, an additional \$75.00 will be applied for the collections management.
- In the event you do not meet your financial commitment, a finance charge will be added to each month a statement is sent.
- I certify I have read and understand the information above. To the best of my knowledge, the preceding questions have been accurately answered.

**PLEASE DO NOT SHARE MY PERSONAL OR FINANCIAL INFORMATION WITH THE FOLLOWING:**

Spouse     Parent(s) (Mother/Father)     Adult Child     Other: \_\_\_\_\_

**Signature of Patient  
Or Parent if Minor:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_