

# Welcome To

## **Dr. Vincent D. DiMento's Office**

**It is an honor and a compliment to have you as a patient!**

**SyracuseFamilyDentist.com**



Thank you for taking the time to review our OFFICE POLICIES. Please let us know if you have any questions or concerns. We are here to assist you.

**Patients cannot be seen until all paperwork is read signed and completed**

Minors must have a guardian signature

### **APPOINTMENTS:**

- Any patient under the age of 18 must be accompanied by a parent for all appointments
- Reminder appointment phone calls and 3-week reminder postcards are a courtesy to our patient's. Please understand it is your responsibility to know when your appointment is. If a message is left PLEASE call us to confirm you received the message.
- Non-emergency cancellations on the same day may result in a fee as well. Please help us to serve you better by keeping scheduled appointments. Kindly give 48 hours for any cancellation. Missed appointments will result in a \$50.00 "no show fee" for chronic offenders.

**EMERGENCY COVERAGE:** Please contact our office. If office is closed there will be a message on answering machine with appropriate phone numbers to contact us.

**INSURANCE & FINANCIAL INFORMATION:** We submit and file your insurance claims for you as a courtesy. Please verify with our office staff any questions pertaining to your insurance "prior" to appointment. *Our office does not participate with ANY insurance companies, nor Medicare or Medicaid.* You must notify us of ANY changes in your insurance coverage **PRIOR** to your visit.

Please be familiar with all your insurance terms and frequencies such as "*USUAL AND CUSTOMARY*" rates. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. (See our link on our web page for further information on area rates) *You are responsible for payment regardless of any insurance company's "arbitrary" determination of usual and customary rates quote.*

If you have insurance, we will gladly help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of your insurance and our financial policy. Please ask if you are unsure of anything. We require a copy of ALL insurance identification cards and a copy of a patient's license or ID card.

**PLEASE READ THE OTHER SIDE**



Please verify with your insurance carrier your dental coverage “prior” to your appointment. Many insurance provider directories are not up to date and sometimes we cannot access that information as quickly as needed. We MUST emphasize that as medical care providers and **being a NON-participating practice (out of network)**, our relationships are with you, NOT your insurance company. All charges are your responsibility from the date the services are rendered. It is therefore, neither our place, nor our policy to contact insurance companies to establish why they have not made payment or why payment is less than the submitted charges. Once again, we will gladly help you as much as we can. We will submit a “pre” authorization to insurance company for you, just ask. (just note: that is not a “guarantee” that your insurance company will pay that amount!). If an insurance carrier has not paid within 60 days of billing, any unpaid balances are due and payable in full from you immediately.

*We accept Cash, Check, Visa, MasterCard, American Express, Discover Card, Flex Account Cards and Care Credit*

We will submit for most insurance’s providing:

- All patient forms are filled out and the information is correct
- We are able to verify coverage by telephone or internet and have a complete mailing address and current phone number
- You have understood and signed (in computer) this document

**Please be prepared at appointment time to pay your patients responsibility portion not covered by your insurance (similar to a co-pay, this is just an estimate).** Please understand that payment of your bill is considered part of the treatment. You will receive a billing statement for any unpaid balances, co-insurance or charges determined **not covered** under your policy. Interest will accrue and will be added to all accounts over 30 days. Any disputes with balances due must be brought within 30 days of 1<sup>st</sup> billing.

We realize that temporary financial problems do arise and we encourage you to contact us promptly for assistance in the management of your account. To avoid any misunderstandings, we invite you to discuss any financial problems or hardship you may have with our financial manager and/or office manager. Please inquire as to payment options that our office may offer.

ASSIGNMENT OF BENEFITS:

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree this authorization will cover all medical services rendered until such authorization is revoked by me in writing. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health status or changes in my insurance status prior to appointments. In the event my account is assigned for collection, I agree to pay an additional collection fee – the greater of \$25.00 fee or 30% collection fee based on the total amount overdue as well as any associated attorney fees.

**PLEASE SIGN THIS RELEASE AT FRONT DESK ON SIGNATURE PAD**

**THANK YOU & HAVE A GREAT DAY 😊**