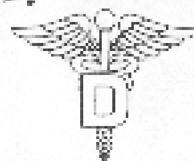
Family and Cosmetic



Dental Care, PA

John J. Nazzaro, D.M.D.

David M. Stramback, D.D.S.

FINANCIAL POLICY:

It is our pleasure to assist you in maximizing your insurance benefits by completing your dental forms. However, FINANCIAL OBLIGATION for dental treatment is between you and our office. All your estimated co-insurance and deductibles are due in FULL at the time services are rendered. We accept Cash, Check, Visa, Master card and Care Credit.

The full treatment balance remains your responsibility until the insurance pays the claim and if the insurance does not pay within 30 days, we will expect you to pay the balance in full. A credit or a refund will be issued in the event of an overpayment. Any balances not paid after 30 days will incur finance charges of 1.5% per month. If the balance is not paid in full by 45 days, the account will be turned over to a collection agency and a $50.00 fee will be added to your balance. Once the account goes to collections, all future dental appointments much be paid in full and you will be reimbursed by your insurance.

BROKEN/MISSED APPOINTMENT POLICY:

We certainly understand that occasionally, circumstances arise that prevents patients from keeping their appointments. It happens to the best of us! We at Family and Cosmetic Dental Care, PA, are proud of our reputation for being prompt and not having patients wait. We feel that we deserve the same respect with our patients keeping their appointments. WE REQUIRE 24 HOUR NOTICE TO CANCEL AN APPOINTMENT. A $25.00 FEE PER ½ HOUR CANCELLED APPOINTMENT WILL BE CHARGED FOR CHRONIC OCCURRENCES. WE THANK YOU IN ADVANCE FOR YOUR COOPERATION AND UNDERSTANDING IN THIS MATTER.

X____________________________________ Date: ____________________
Signature of Patient/Parent if Minor

IF YOU WOULD LIKE TO LEAVE A CREDIT CARD ON FILE, PLEASE FILL OUT THE INFORMATION BELOW:

Circle one: Visa Mastercard Care Credit

Name on card: ________________________________ EXP Date: ____________________

Credit card# ____

I give my permission to charge any co-insurances that I owe
Family and Cosmetic Dental Care, PA, to the credit card listed above. (Before this is done you will be called in advance). This authorization will also be valid for any payments made over the phone by me.

X____ Date: ____________
Signature of Patient/Parent if Minor

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