Elaine G. Stolis, D.D.S & Associates, P.C.

OFFICE AND FINANCIAL POLICIES

Thank you for choosing us for all of your dental needs. We are committed to providing you with excellent care and convenient financial arrangements in order to insure the best possible experience. Our financial arrangements are based on an open and honest discussion of recommended treatment plans. Please read the following, sign and return.

PAYMENT

Payment in full of services planned for that treatment day is expected at the time of service unless prior arrangements have been made with our financial coordinator. Please ask about our several payment options. We accept cash, personal checks, Visa, MasterCard, and Discover.

INSURANCE

Our office is committed to helping our patients maximize their insurance benefits. As you may be aware, dental insurance is extremely complex. We are always available to answer your questions, however, your insurance policy is an agreement between **you and your employer/insurance carrier** and as a dental provider, we are **not** party to that agreement. Your patient portion must be **paid before or at the time of service**. We ask our patients to provide us with their complete dental insurance information. If the information provided is incorrect, you will be responsible for payment in full immediately and submission of claims for any treatment rendered. As a service to our patient, we will process primary and secondary insurance claims for services and allow them 45 days to render payment in full. After 60 days, the patient is responsible for the entire balance and it will be due in full. The qualities of insurance policies vary greatly; therefore we can **estimate** your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts.

MINORS

Payment for services for the treatment of minors is the responsibility of the adult accompanying that minor.

MISSED APPOINTMENTS

Once an appointment has been made, please remember that this time has been specifically reserved for you. We will make every effort to remind you of your appointment but, ultimately your appointments are your responsibility. We reserve the right to charge a **fee of $75.00** per hour scheduled for any appointments missed or cancelled within a 24-hour period of the appointment.

SERVICE CHARGES

We will charge a 1.5% monthly (18% annual percentage rate) or billing charge which will be applied to all accounts over 90 days past due. We will **charge $50.00** for all returned checks. Any fees incurred to collect payment from a professional agency will be billed to and payable by the patient or the patient's responsible party.

FINANCIAL CONSENT

The patient or responsible party agrees to be fully responsible for the total treatment performed in this office.

I understand and agree to this Office and Financial Policy and Agreement.

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Signature of Patient/Responsible Party Date