OFFICE FINANCIAL POLICY

PATIENTS WITH INSURANCE

We will provide you with an *estimate* of the total fee expected. Your estimated portion is due in full on the day of treatment. As a courtesy, we will file your insurance. **If after 40 days we have not received payment from your insurance company, the balance becomes your responsibility.** We will bill you and allow you 30 days to settle your account.

When estimating insurance coverage, we stress the word ***estimate*** as dental benefits are determined by each patient's dental contract. Insurance is a contract between **you** and **your insurance company**. We are not a party to that contract. We will not become involved in disputes about charges, secondary insurance, usual and customary charges etc. other than to supply factual information as necessary.

Initial _____

PAYMENT OPTIONS

For your convenience, we offer the following payment options:

- **Cash**
- **Check** ($30 charge for all returned checks)
- **Visa, Master Card, Discover, American Express**
- **Monthly Payments** (Short-term and long-term financing through **Care Credit** a dental payment plan with no interest plans for up to 12 months*)

CANCELLATION AND TARDY POLICY - 24-HOUR CANCELLATION POLICY

We recognize that unexpected situations may arise, but as a courtesy to our patients and Dr. Roznik, we require that you give a **minimum of 24 hours notice** when cancelling or rescheduling a scheduled appointment. Unless an emergency occurs, leaving a message after hours on our voice mail does not allow us enough time to fill your reserved spot.

Please note that we charge a $50.00 *late cancellation* or *no show* fee. **Initial** _____

In addition, if something unforeseen arises and you are going to be **more than ten minutes late for your appointment** we may ask you to reschedule and a late fee may be applied. While we do understand late cancellations can happen, if your account is reflective of more than 2 late cancellations or no shows within a 12 month period, it may be necessary to bill your account for a percentage of the original scheduled appointment charge. This fee will not exceed 25% of the amount the missed visit totals. This amount will be billed to your account and a statement will generate and we will allow 30 days to pay the balance. This amount will be non-refundable and cannot be applied as a credit to any future treatment.

Our goal is to be respectful of all our patients' time and their needs. We appreciate your cooperation with our policies.

Patient Name (printed): _____

_____ _____

Signature of Patient/Guardian **Date**