



2603 PARK AVENUE | SOUTH PLAINFIELD, NJ | 07080 | 908-769-5200

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions; please discuss them with our billing staff. We are dedicated to providing the best possible care and service to you, along with your complete understanding of our financial policies.

Payment is due at the time of service unless other arrangements have been made in advance by either yourself or your dental plan coverage. For your convenience, we accept cash, check, and any major credit card (Visa, Master Card, Discover, Etc.).

Your insurance is a contract between you and your insurance company. As a courtesy, after the dental visit, we will perform insurance estimates and will electronically submit your insurance claim for you. If we later receive a check from your insurer, we will refund any overpayment to you.

All dental plans are not the same and do not cover the same services. In the event your dental plan determines a service to be "not covered" you will be responsible for this amount. Therefore, we will accept payment in full at the time of the service.

Please note, a divorce decree is legal agreement binding only upon the two parties who made this agreement. Regardless of whom the judge deemed financially responsible for dental bills, the adult accompanying the child is responsible for payment of services rendered to a child patient.

In the event payment is not made within 60 days of the service is provided, you will be assessed an additional 2% per month on the balance more than 60 days in arrears. Once an account is in arrears in excess of 90 days, we may elect to seek assistance in collecting the balance and you will share the responsibility for any and all costs incurred in doing so.

MISSED / LATE APPOINTMENT(S) POLICY: Although, we make every attempt to remind you of your scheduled appointment, it is your responsibility to remember all appointment date(s) / time(s). The doctors have reserved this time, especially for you to meet your dental needs. Cancellations require a 24-hour prior notice, or you will be charged \$50.00 missed appointment fee per every half hour. This fee covers the portion of our overhead, which still has to be paid whether the patient is present, or not. Late arrivals (more than 15 minutes) may require rescheduling your appointment to another day. Please be on time so the doctors can provide the best treatment for you.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time by the practice.

Printed Patient Name

Printed Guardian Name

Signature of Responsible Party

Date