

**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 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 15 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**

We understand that it may be difficult to afford out-of-pocket care. For your convenience, we offer the following payment options

- **Cash**
- **Check**
- **Visa, Master Card, Discover**
- **Monthly Payments** (Short-term and long-term financing through **Care Credit** or **Chase Health Advance**, 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 things come up for all of us but, as a courtesy to our other patients and Dr. Roznik and his team, we require that you cancel any appointment with a **minimum of 24 hours notice**. Sufficient notice allows us to fill the open appointment time with another patient needing treatment. Leaving a message after hours on our voice mail does not allow us enough time to reschedule. **Once a spot is reserved, IT IS YOUR 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 will consider this a late cancelation and ask that you reschedule your visit. We understand that people get delayed by circumstances beyond their control but one late patient can mean all subsequent patients scheduled that day are delayed.

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

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date