Allendale Family & Cosmetic Dentistry
70 W Allendale Ave Suite B • Allendale, NJ 07401
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FINANCIAL AGREEMENT
Thank you for choosing us to provide your dental care. Our goal is to help you establish excellent oral health. We are committed to helping you determine the most appropriate treatment for your dental needs and desires. Our philosophy in serving people is to be informative, honest and forthright. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement, please do not hesitate to ask the office staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- Unless otherwise specified by your contracted policy, you are responsible for our fees and not what your insurance company allows, all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services along with deductibles and co payments are due at the time of treatment.

PAYMENT POLICY

- We accept cash, personal checks, and debit cards, Visa, MasterCard, Discover and American Express.
- We offer in-house monthly financing through CareCredit.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 30 days of the statement date, to avoid carrying charges.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimates of fees, and payment is expected at each visit for services rendered in full unless prior arrangements were made in office with one of our staff.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exceptions. This office will NOT attempt to collect payment from a parent that is not present in the office at the visit.

RETURNED CHECKS: Bank fees and processing charges will apply when the bank returns a check.

PAST DUE ACCOUNTS: Open accounts with no acceptable payment activity for 60 days will be considered past due.

COLLECTIONS: Open accounts with no acceptable payment activity for 120 days will be automatically placed with our collection agency. You will be responsible for the original past due balance, along with any additional billing and collection agency fees.

We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately, so we may assist you in the management of your account.

CANCELLATION POLICY: When you are scheduled to see the Doctor or the Hygienist, we require a 24-Hour Notice of Appointment Cancellation. Your appointment time is reserved especially for you. We understand that emergencies such as illness, etc. do occur and we do not wish to penalize our patients for unavoidable situations. But we do want to discourage repeated abuse of our scheduling process, which is ultimately unfair to those patients who are diligent about keeping their appointments. We DO NOT charge patients for missed appointments or short notice cancellations; however, **we reserve the right to terminate professional treatment of any patient when scheduled appointments are continuously not kept.**

CONSENT & AUTHORIZATION: I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Allendale Family & Cosmetic Dentistry. Without reservation, I agree to abide by the policies outlined herein.

FORMS COMPLETED BY:

Name: _____ Signature: _____ Date: _____
(Name of patient/responsible party) (Signature of patient/responsible party)

Reviewed by staff member: _____Date: _____