Family Dentistry Of Keyport
Phone: 732-264-3963
Fax: 732-264-9411

Financial and Appointment Policy

We realize that every person's financial situation is different. For this reason we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

Dental Insurance:

We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, we can make no guarantee of any estimated coverage. Please note that your dental policy is an agreement between you and the insurance company, and we ask that all patients be directly responsible for all charges.

Payment Options:

Payment of patient portions may be made with the following:

- Cash, Check or Money Order. We are happy to offer a 5% pre-payment courtesy for all treatment paid in full prior to commencement of treatment plan.
- Major Credit Cards (Vis, MasterCard, American Express)
- Payment Plan. For patients who desire a monthly payment plan, we can make arrangement with you and customize a payment plan. (Care Credit)

Appointment Cancellation Policy:

We work hard at treating patients as unique individuals. We try to remain responsive to each person's needs. When you book an appointment with us, you have our undivided attention for the length of that appointment.

Short notice cancellations or missed appointments increase our cost of providing dental care – costs that ultimately must be passed onto you, our patient. More importantly, missed appointments do not allow us the opportunity to offer the appointment time to other patients seeking our care. For these reasons, we ask that you read and agree to these expectations:

- Please respect our time and that of other patients by giving us a minimum of 2 business days' notice to cancel or change an appointment.
- Patients with appointments which are missed or cancelled with less than 24 hours' notice may incur a charge of $100 per missed appointment.

I agree that I have read this information and fully understand the financial and appointment policies for the office of G&A Family Dentistry, DDS. I authorize this office to release any necessary information to expedite insurance claims. I understand that I am solely responsible for all charges, regardless of insurance coverage. I agree to pay any collection fees or attorney expenses should it be necessary to refer to this account to collections and I understand that any unpaid accounts will be reported to credit bureaus.

Patients Signature or Responsible Party _____ Date: _____

45 Main St
Keyport, NJ 07735
keyportdentistry@gmail.com