OFFICE POLICY

We appreciate that you have chosen our office to take care of your dental needs. We are committed to excellence and strive to make your visit as pleasant as possible.

If you find that you are not able to keep a scheduled appointment, please call us as soon as possible so we can offer that time to another patient who may need to be seen. As a courtesy, we will try to call you 1 business day prior to your appointment as a reminder, however it remains your responsibility to keep the arranged date and time of your appointment. **A minimum charge of $37 will be applied to your account if you fail to show for a scheduled appointment, or if we are not given a 24 hour notice of cancellation of an appointment. A higher fee will apply to appointments that are scheduled in excess of 1 hour.**

PATIENTS WITH INSURANCE: Insurance claims are filed for you as a courtesy. Please remember that your insurance policy is a contract between you and your dental insurance carrier. If your insurance company pays only a portion of your bill or rejects your claim, you are responsible for any balance due. Payment of your deductible and/or estimated copayment is expected at time of service, unless arrangements have been made in advance.

PATIENTS WITH NO INSURANCE: Payment in full is expected at time of service, unless payment arrangements have been made in advance.

We are a fully approved and accredited user of the Discover, Visa and MasterCard Health Care Program which will enable you to use your credit/debit card to make payments on your account.

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IMPORTANT INFORMATION - PLEASE NOTE

If, for any reason, you are not able to pay your account balance in full at the time that it is due, please contact us immediately - we will be happy to discuss setting up a monthly payment plan to assist you. We prefer to work with our patient to resolve a bill rather than send an account to collections - taking this action does not benefit us, and it will have a negative impact on your credit!

DELINQUENT/OVERDUE ACCOUNTS - In an effort to control our bookkeeping costs, and in turn to help control your dental fees, we ask that payment be made at the time services are rendered. In the event that an account becomes delinquent, a 1 1/2% interest charge (per month) will be applied to any outstanding balance owed. If an account is forced into collection action, the patient (and/or their responsible party) agrees to pay all costs involving collections, including but not limited to court costs, attorney and/or collection fees of 33 1/2% of the total amount due, and any accrued interest charges from the date at which the account became delinquent.

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FINANCIAL RESPONSIBILITY

*Is the Patient the person responsible for payment on the account? Yes_____No_____
*If not, please provide name, address and phone number of responsible party:

_____

*Patient's relationship to responsible party: _____
*How may we expect to receive payment for any balance not covered by your dental insurance?
*cash____ *check____ *credit card____

I have read, understand and agree to the office policy of Dr. Paul J. Ingrao, D.D.S.

_____

Signature of Patient/Responsible Party **Date**