

# OUR FINANCIAL POLICY

Welcome to our practice. We appreciate you choosing us for your dental care. Our goal is to make your time spent with us comfortable and educational.

As a patient in our practice, your health is our most important concern. We believe by understanding your dental concerns and discussing dental treatment options with you, will help us achieve this goal. In addition, we have found that a clear understanding of the related financial responsibility relieves some of the anxiety associated with visiting a health care provider.

Understanding that financial considerations may hinder patients from obtaining needed dental care, we desire to work with you to structure a financial arrangement that is mutually agreeable.

## Payment Options...

Dr. Nicolini will perform a thorough examination which will be the basis for a comprehensive treatment plan tailored to achieve your dental needs and desires. From this information, an estimate for services will be determined. Treatment fees quoted are subject to change after 90 days. Available payment options are as follows:

1. Cash or check: Payment in full upon 1<sup>st</sup> day of a professional service receives a 5% savings.
2. Credit cards accepted are MasterCard, Visa and Discover.

## Authorization and Release

*I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Delinquent accounts assigned to a collection agency are responsible to pay all collection costs including reasonable attorney fees, and accrued interest. I understand that when appropriate, credit bureau reports may be obtained.*

X \_\_\_\_\_  
Signature of patient or parent if minor Date

## CANCELLATION POLICY:

There are many times that our patients require urgent emergency treatment and therefore require an appointment as soon as possible. When patients give the office advanced notice of their need to cancel a scheduled appointment, this time can then in turn be allocated to these patients in urgent need of treatment.

Bearing these special needs in mind, the office requires a minimum of **48 hours notice** if an appointment must be cancelled. If less than 48 hours has been given to cancel an appointment, then a **\$150.00 fee\*** will be assessed. Please note that this fee is not covered by dental insurance and payment is the patients' responsibility.

\*Exceptions will be made for illness or personal tragedy.

X \_\_\_\_\_  
Signature of patient or parent if minor Date