

FINANCIAL POLICY
DR. GEORGE DERENZO

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST DENTAL CARE AVAILABLE. WE FEEL THAT EVERYONE BENEFITS WHEN DEFINITE FINANCIAL ARRANGEMENTS ARE AGREED UPON. IF YOU HAVE DENTAL INSURANCE WE WILL HELP YOU RECEIVE YOUR MAXIMUM ALLOWABLE BENEFITS. IN ORDER TO ACHIEVE THESE GOALS WE NEED YOUR ASSISTANCE AND UNDERSTANDING OF OUR PAYMENT POLICY.

WE FILE CLAIMS AS A COURTESY TO ALL OF OUR INSURANCE PATIENTS. WE ASK ALL PATIENTS TO PAY THEIR ESTIMATED FINANCIAL PORTION AT THE TIME OF SERVICE; THIS INCLUDES YOUR ANNUAL DEDUCTIBLES. PLEASE UNDERSTAND THAT ALL SERVICES MAY NOT BE COVERED BY YOUR DENTAL PLAN. YOU WILL BE RESPONSIBLE FOR ALL AMOUNTS NOT PAID BY YOUR INSURANCE COMPANY.

IF YOU ARE SENT A STATEMENT FROM OUR OFFICE, PAYMENT IN FULL IS DUE WHEN YOU RECEIVE IT. THIS OFFICE RESERVES THE RIGHT TO CHARGE A MONTHLY LATE CHARGE OF 4 % ON PAST DUE ACCOUNTS. IF YOUR ACCOUNT IS SENT TO A COLLECTION AGENCY, THIS OFFICE WILL CHARGE THE ADDITIONAL COLLECTION AGENCY FEES OF UP TO 45%. PLEASE BE FAMILIAR WITH YOUR DENTAL INSURANCE POLICY. THE CONTRACTS ARE BETWEEN YOU AND YOUR INSURANCE COMPANY. IF YOU HAVE A QUESTION OR CONCERN WITH YOUR INSURANCE PAYMENT, PLEASE CALL THEM DIRECTLY. WE WILL ASSIST YOU IF NEEDED.

SEDATION PATIENTS:

A DEPOSIT OF \$50.00 IS REQUIRED TO SECURE AN APPOINTMENT FOR YOUR CHILD. IF THE APPOINTMENT IS BROKEN WITHOUT **48 HOURS NOTICE**, THE DEPOSIT IS NON-REFUNDABLE.

MEDICAID PATIENTS

WE HAVE CHOSEN TO PARTICIPATE WITH MEDICAID TO HELP THE MANY CHILDREN THAT NEED DENTAL CARE. IN ORDER FOR OUR PRACTICE TO DO THIS, IT IS NECESSARY THAT THE PARENT/GUARDIAN INSURED THAT THE CHILDREN KEEP THEIR APPOINTMENTS AND BE ON TIME. IF YOU ARE LATE FOR AN APPOINTMENT, WE MAY BE UNABLE TO TREAT YOUR CHILD.

DUE TO EXCESSIVE BROKEN APPOINTMENTS, WE HAVE ADOPTED THE FOLLOWING POLICY:

IF YOU FAIL A DENTAL APPOINTMENT, **A CHARGE OF \$75.00** WILL BE POSTED TO YOUR ACCOUNT. UNTIL THE FEE IS PAID, NO ADDITIONAL APPOINTMENTS WILL OCCUR. IF YOU MISS MORE THAN ONE APPOINTMENT, **YOU WILL BE DISMISSED FROM THE PRACTICE** AND REQUIRED TO SEEK TREATMENT ELSEWHERE.

REMEMBER, A BROKEN APPOINTMENT NOT ONLY HURTS YOU BUT ALSO A WAITING CHILD THAT COULD HAVE BEEN SEEN IN THAT TIME PERIOD.

YOUR COOPERATION WITH THE ABOVE POLICY WOULD BE APPRECIATED.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

DATE _____