

OUR FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to the success of your treatment. Part of this commitment is understanding your responsibility for the payment of your account balance.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

WE ACCEPT CASH, CHECK, VISA/MASTERCARD, DISCOVER AND AMERICAN EXPRESS. We offer special financing through Care Credit for those who need extended payment options. Please note all special payment arrangements must be finalized prior to treatment.

ADULT PATIENTS

Adult patients are responsible for full payment at the time of service unless specific arrangements are made prior to the start of treatment.

MINOR PATIENTS

The adult accompanying a minor and the parents/guardians are responsible for full payment at the time of service.

INSURANCE

It is our pleasure to assist you in maximizing your insurance benefits and, as a courtesy; we will file your claims for you. We will estimate your deductible and the portion not covered by your insurance, and this amount is due and payable at the time of service. As it is impossible for us to know the details of every insurance policy, our estimate may differ from the actual coverage, and your account will be adjusted when your claim is paid. Our practice is committed to providing the best treatment for our patient and we set our fees based on the quality of treatment we provide. The insurance policy is a contract between you and the insurance company. You are ultimately responsible for the fees on the account regardless of insurance coverage.

PATIENT RESPONSIBILITY AND ADDITIONAL TERMS

Accounts unpaid after 60 days from the date of service are subject to a delinquent fee of \$25.00. Furthermore the unpaid balance is subject to a 1% monthly (12%Annual) finance charge. If we have to submit your unpaid account to a collections process you will be responsible for all charges our practice incurs; including court costs and reasonable attorney's fees.

MISSED APPOINTMENTS

Unless appointments are cancelled at least 48 hours in advance, our policy is to charge for a missed appointment. A fee of \$60.00 will be billed to your account and is **non-refundable**. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to the terms of the Financial Policy of the office of Dr. Toby P. Kravitz, DDS

X _____
Signature of Patient or Parent of Minor Patient

Date _____