

LISA GITELSON, DMD, PC
DAVID L. WILSON, DMD

FINANCIAL POLICY

We are committed to providing each patient with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to do this, we need your assistance, and your understanding of our financial policy.

Regarding Non-Insured Patients

Payment in full is due at the time of service unless prior arrangements have been made.

Regarding Insured Patients

The estimated non-insurance portion (co-pay) for treatment rendered is due at the time of service. While the filing of insurance claims is a courtesy to our patients, all charges are your responsibility from the date the services are rendered. If your insurance company has not paid on your account in 60 days, the balance will be expected in full.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance; however, please understand:

- Your insurance is a contract between you, your employer, and the insurance company. We are NOT a party to that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services *they* will not cover.

We accept cash, check, Visa, MasterCard, American Express, or Discover Card. Information regarding extended payment plans through CareCredit is also available.

Returned checks will be subject to an additional fee of \$35. After 60 days, all accounts are subject to a Finance Charge of 1.5% of the unpaid balance (or a minimum charge of .50 cents), which is an Annual Percentage Rate of 18%. A minimum charge of \$50 may also be applied for any missed appointment or appointment not cancelled with a 24 hour notice.

If you have any questions about the above information or are uncertain regarding insurance information, PLEASE do not hesitate to ask us. We are here to help you.

“I understand and agree that (regardless of my insurance) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this sheet.”

NAME (please print) _____ Date _____

SIGNATURE _____ Date _____

PARENT/GUARDIAN (if minor) _____ Date _____