Office Policy

Financial Policy

Thank you for choosing ***Pamela J. Asseff, DDS*** to serve your dental needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

- All patients must complete our Patient Information & Insurance form prior to seeing the doctor.
- We accept CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS & DISCOVER
- We offer financing through CARE CREDIT Initial_____

Regarding Insurance

We will file all insurance claims as a courtesy to our patients. This does not transfer your financial obligation to your insurance company. We cannot bill your insurance company unless you give us all necessary information. Your insurance policy is a contract **between you and your insurance company**. We are not a party to that contract. **You are responsible for the estimated amount due on the date services are rendered**, we will then bill you for any balance left after your insurance company pays us and all applicable write-off's have been taken. **If your insurance company does not pay within forty-five (45) days, the balance will be transferred to you, and you will be responsible for it.**

- Please be aware that some of the services provided may be non-covered services and not considered reasonable & customary under your insurance policy.
- Regarding Manage Care & PPO: In plans where we are a participating provider, all co-pays and deductibles are due at the time of treatment.
- Non Insured Patients: Full payment is expected for services rendered. Initial_____

Delinquent Accounts

All accounts Sixty (**60**) days old are sent to our collection department. **Please note that you will also be charged the collection companies fee of 34% in addition to the amount owed.** Initial_____

Failed or Cancelled Appointments

Unless appointments are cancelled at least **48 hours** in advance, our policy is to charge **$50.00 per each scheduled hour** for any missed appointments. Please help us serve you better by keeping all scheduled appointments. We will not offer appointments to patients who fail multiple appointments without giving notice. Although we strive to give reminder/ confirmation phone call, text, or email of your scheduled appointment, **you are still responsible for arriving for said appointment or giving appropriate notice for cancellation even if you do not receive this call, text, or email.**

Initial_____

Please understand that you are financially responsible for all charges incurred in our office.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Patient Name: (please print) _____

Patient or Responsible party Signature: _____

Relationship to Patient:_____

Date: _____

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