MONICA CHAPOKAS PALUSSO, D.M.D.
FAMILY AND COSMETIC DENTISTRY

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FINANCIAL POLICY

We are committed to providing you and your family with the best possible care.

If, at any time, you have questions regarding proposed treatment options, fees, or insurance, please ask. ***We are here to help!***

Payment is due at the time services are rendered. ***We accept cash, checks, Visa, Mastercard, and Discover. Financing is also available through Carecredit.*** We are happy to handle the submission of your insurance claims for you; however, your estimate, share of cost is due at the time of treatment. For any returned check, there will be a minimum $25 charge or up to the amount of the check. We acknowledge the temporary financial problems may affect timely payment of your account If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

We must emphasize that as dental care providers, our relationship is with you, not your insurance carrier. ***While the filing of claims is a courtesy that we are happy to extend to our patients, all charges are the patient's responsibility. We are not able to guarantee your insurance coverage or the amount they will pay.*** If you have questions concerning your dental plan, we recommend you contact your dental insurance company for further clarification. Dental pre-authorizations can be done at patient's request. An administration fee may apply for pre-authorization which need to be processed more than one time due to expiration dates and/or patients delay in treatment pre-authorizations are not a guarantee of payment.

Appointment times are reserved exclusively for you. Kindly give 48 hours notice if you are unable to keep your reserved time. A fee of $50.00 may apply for continuous broken appointments resulting in less than 48 hours notice.

Balances over 30 days may be subject to interest charges of 1.5% per month or 18% per year. Delinquent accounts may be subject to collection costs.

We look forward to caring for you and your family soon. Thank you again for choosing our office to assist you in maintaining optimal dental health.

PATIENT NAME _____ **DATE** _____

I understand and agree that (regardless of insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

SIGNATURE OF PATIENT _____ **DATE** _____