325 University Ave.
Syracuse, NY 13210
(315) 476-3552

Financial Statement and Office Policies 2022

The following financial and office policy is required prior to any dental treatment. Please understand we do not want to see financial constraints and/or broken appointments interfere with dental care and the doctor/patient relationship. To facilitate your payments, the following options are listed. Please read them carefully, initial and sign all designated lines.

Patient Name: _____
Name of Person Responsible for Account: _____
Relationship to Patient: _____

Payment Options
IF YOU DO NOT HAVE INSURANCE: Payment is due in full at the time treatment is provided. We do not give discounts. For your convenience we accept cash, personal check, MasterCard/Visa/Discover/Amex and Care Credit (with approval), _____ (initial)

IF YOU HAVE INSURANCE: We will submit your insurance claim to your insurance carrier as a courtesy to you. The amount of coverage paid by your insurance carrier may be based on your insurance company's Usual and Customary Rates and/or Fee Schedule. If your insurance carrier only pays patient directly, you will be responsible to pay at the time treatment is provided. You are responsible at the time of your appointment for any deductible or co-copayment not covered by the insurance company, as well as any remaining balance that the insurance company fails to pay. If your insurance company does not remit payment within 30 days, the balance will be due from you. _____(initial)

DOWN PAYMENTS: We try our best to estimate what your out-of-pocket will be. A 1/3 down payment of the estimated cost is required to schedule and hold your appointment on all major procedures. The down payment will be subtracted from the estimated cost and the remainder will be due at time of appointment. In the event your insurance covers the procedure at 100%, we will require a $25 refundable deposit in order to schedule and hold your appointment. _____(initial)

ACCOUNT BALANCES: If your account balance becomes 30 days late, a $20.00 late fee will be applied each month. If your account becomes 90 days late, your account will be sent to collections. All fees from the collection agency will be the patient's responsibility. If your account is in collection or on late standing, no appointments will be given until the balance is paid in full. Future visits due to late accounts will result in the patient paying in full at the time of service. _____ (initial)

BROKEN APPOINTMENT POLICY: Appointments in our office are reserved exclusively for each patient and are also customized according to individual needs. For this reason, if you are unable to keep your reserved appointment please give us at least a 24 hour notice. If you cancel your appointment the day of or NO SHOW your appointment, a refundable $25.00 reschedule fee will be required to reschedule. The deposit will be refunded back to you the day of your rescheduled appointment. After 2 "no show" appointments we will assume you no longer wish to be a part of practice and a dismissal letter will be mailed to you. _____ (initial)

We reserve the right to reschedule your appointment if you are 10 minutes late. _____(initial)

Additional Costs: I understand and agree to pay for ALL cost involved with a collection agency, small claims court and/or an attorney's fees if my account is not paid for in full. _____ (initial)
Returned Checks: There will be a $40.00 returned check fee applied to your account if a check is returned. The account then must be paid by cash or credit card. _____ (initial)

Signature of Responsible Party: _____ Date:_____