MATT **BOLAMPERTI**, D.D.S.
Cosmetic & Family Dentistry

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OUR FINANCIAL POLICY

We are committed to providing you with the highest quality dental care. If you have dental insurance, we will gladly file your insurance for you. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

Fees must be paid in full at the time of service unless alternate financial arrangements have been made. The following financial options have been made available for you:

Fees paid per appointment for those services rendered. Payment may be made with cash, check, VISA, or MASTERCARD. Returned checks will be subject to additional fees.

Full pay cash discount: We offer a 5% discount for all services over $500 paid in full by cash or check prior to the commencement of services.

Your Health Credit offers a healthcare finance program. Subject to credit approval, special financing is available. Ask for details.

We will gladly process your insurance claim form, discuss your proposed treatment and answer any questions relating to your insurance. Please keep in mind the following information:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Your policy may base its allowance on a fee schedule which may or may not coincide with current acceptable fees in our area. Insurance companies vary greatly in the types of coverage available.

3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that our relationship is with you, and not your insurance company. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered. Balances older than 90 days will be subject to additional collection fees and finance charges at a rate of 1.5% per month and 18% annually.

Cancellation policy - Your appointment time is reserved just for you. If you must cancel an appointment, we require at least 24 hours notice or a charge will be made to your account.

If you have any questions about the above information, please feel free to ask us.

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

Signature (Patient or responsible party) **DATE**