FINANCIAL AND OFFICE POLICIES

At Schwartz Family Dentistry, we are committed to providing you with personal care. We ask that you carefully read and sign this statement, which outlines our policies regarding payment, insurance claims and scheduling.

Payment:

You are responsible for full payment at the time of services. Full payment may include partial coverage from your insurance carrier, but the details must be arranged prior to treatment. We accept **Cash, Check, Visa, MasterCard, and Discover. THERE IS A $35.00 SERVICE CHARGE FOR ALL RETURNED CHECKS.**

Payment Plans:

We offer short term payment plans for established patients. These must be prearranged and require a credit card number to insure against payment delinquency. We require half of the total balance down and the remainder bull must be paid withing 6 months. Outstanding balances for more than 60 days acquire a 1.5% finance charge monthly until the balance is paid in full.

Insurance Coverage:

It is your responsibility to know the definition of your unique insurance plan. Please understand that your insurance coverage is between you, your employer and your insurance company. We are **NOT** part of this contract. We "participate" with many carriers, meaning we will accept payment directly from them. Participate does not mean we will automatically accept their reimbursement portion as full payment. **Depending on your individual coverage you may have a different patient obligation than is estimated at time of service**. Insurance policies and claims **DO NOT** always cover full payment. **THE REMAING BALANCE IS YOUR RESPONSIBILITY.**

GHI Participants:

Please note that Emblem Health/Group Health, Inc does not accept assignment of benefits from us. Full payment is required to our office on the date of service. Our office will submit the claim to GHI and the patient will be reimbursed according to their individual coverage and fees.

Missed Appointments:

Patients must call within 24 hours to cancel or reschedule appointments. If you fail to do so, a $35.00 missed appointment fee will be added to your account.

I have read the above and understand and agree to this policy.

Name_____

Signed_____ **Date**_____