General Dentistry of Cape Cod

ANDY UZPURVIS, DDS PAUL L. BOOTH, DDS

Financial Agreement

Thank you for choosing us as your dental care provider. We are committed to providing optimal treatment for our patients and establishing an understanding between us as a team. Please read and sign the following statement of our financial policies. If you have any questions, please do not hesitate to ask.

Payment

Payment is expected at the time of service, including all co-payments and deductibles. We accept cash, checks, Visa, Mastercard, American Express and Discover. There will be a $35.00 service charge on returned checks. Repeated non-payment may result in your account being turned over to a collection agency and dismissal from our practice.

Missed Appointments

Please make every effort to contact us if you are unable to keep your appointment. We do not charge for appointments rescheduled in advanced or missed in the case of an emergency. While we do make exceptions, it is our policy to bill for appointments canceled on short notice (less than 48 hours) and missed appointments at the rate of $50.00 per 15 minutes of scheduled appointment time. Multiple missed appointments may result in the need to be dismissed from our practice.

I have been informed of the financial policies.

_____ _____

Patient Signature Date

Additional Information for Patients with Dental Insurance

All treatment recommendations are made in the best interest of your oral health, irrespective of insurance coverage limitations. Insurance is simply a supplemental payment. As a service to our patients we are happy to bill most insurance companies directly, however, your insurance policy is a contract between you and the insurance company; balances incurred are always your responsibility, even if your insurance does not pay. We will work with you in maximizing the use of your insurance benefits to the best of our abilities. However, many employers purchase plans, which contain exemptions and riders that are nearly impossible to predict. **It is ultimately your responsibility to know the specifics of your policy and the extent of your benefits.**

Usual and Customary Fees

Our fee schedule is based on prevailing rates for our area. Your insurance company may base its dollar allowance on a fee schedule (Usual and Customary Fee) which differs from current fees for our region: in these cases you will be responsible for the remaining balance.

If you have any questions, our staff is happy to assist you. Please bear in mind that we are not privy to your insurance contract and any information we give is based on general information supplied by your insurance company.

_____ _____

Patient Signature Date

Patients Under the Age of 18

A Parent or legal guardian must accompany all minors for their initial visit. Consent for future treatment may be obtained form the parent at this time allowing older children to complete treatment unattended with payment expected at time of service. The parent signing this agreement is responsible for payment regardless of any agreements from a court.

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Signature of Parent or Responsible Party Date