



Kiran Satashia, D.M.D., P.C.

FINANCIAL POLICY

In developing treatment plans for our patients we are guided by the current standard of care within the dental profession and by our own high standard of ethics and moral responsibility to our patients. Our responsibility is to provide you with the highest quality of care, using the latest concepts and techniques in a clean and safe environment. In order to achieve this goal we need your assistance and complete understanding of our financial policy. You are ultimately responsible for the fees for the professional services provided.

Payment for services is due at the time services are rendered. For your convenience we accept cash, personal checks (for established patients only), and major credit cards. In cases of comprehensive treatment plans that extend over time (such as periodontal, prosthodontic, or extensive treatments) a special payment schedule may be arranged in advance. (____)

For those patients enrolled in a dental assistance plan (commonly referred to as dental insurance) we will be happy to assist *you* in *processing your forms* for your reimbursement. In many cases after your insurance company has verified your eligibility and notified us of assignment of benefits, you will have to pay only your deductible and/or co-pay at each visit. We will wait up to 35 days for your dental insurance to pay the balance. **However, if payment is not received within 35 days then the entire amount becomes due and payable by you immediately.** (____)

The adult parent or guardian who accompanies a minor is responsible for full payment at the time of service. (____)

An appointment is a confirmation that time has been reserved for your treatment. We do not assess a cancellation charge if at least 24 or 48 hours notice is given. **However, a cancellation charge of \$58 per half hour of scheduled time is assessed for each "NO SHOW" or appointment cancelled without 24 hours notice and 48 hours notice for a Saturday appointment.** (____)

Checks returned from your bank unpaid are subject to a \$30.00 processing charge. (____)

Accounts unpaid after 30 days from the date of service incur a finance charge of 1.0% (6% annum) on the outstanding balance (or a minimum monthly charge of \$5.00). (____)

If your account is referred for collection you will be responsible for collection costs in the amount of 33% to 50% depending on the age of the outstanding balance and/or all court costs and reasonable attorney's fees. (____)

We will be happy to discuss your proposed treatment, fees for treatment, and answer any questions relating to your treatment or the professional fees. Please do not hesitate to ask for clarification on any matter concerning your treatment. (____)

For individuals with **dental insurance**, please remember the following:

(1). **Your insurance is a contract between you, your employer, and the insurance company.** We are NOT a party to that contract and there is nothing we can do regarding the coverage provided; as dental care providers our relationship is with you not your insurance company.

(2). Our fees fall within the range authorized by many companies and most of our patients receive maximum assistance from their companies up to the policy limits; however, all patients are responsible for the policy deductibles and co-pays.

(3). A few companies reimburse on an arbitrary "fee schedule" which bears no relationship to the current standard of care or the actual cost of providing services; not all services are a covered benefit in all contracts and some companies arbitrarily select certain services which they exclude. (____)

We realize that temporary financial problems may affect the timely payment of your account. If such problems do arise please contact us promptly for assistance in the management of your account.

If you have any questions about your diagnosis, treatment plan, or any uncertainty regarding the professional fees or your dental insurance plan, please do not hesitate to ask us. We are here to serve you.

I have read and understand the above Financial Policy and agree to abide by it.

Patient (or person responsible for account): _____ Date: _____

Additional family members include: _____

I have reviewed this Financial Policy with the patient (or parent/guardian).

Financial Administrator: _____ Date: _____