SUSAN M. LEONI, D.M.D.

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Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care so that you may fully attain optimum oral health. Everyone benefits when office and financial policy arrangements are understood. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Agreement which we require you to read and sign prior to any treatment.

Regarding Payment

Payment of **estimated** patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:
1) We accept the following forms of payment: Cash, Check, Visa and MasterCard.
2) Flexible payment plans of up to 6 months upon approval with Care Credit®. Approval must be received prior to treatment date
3) Care Credit is used for treatment over $500.00. Applications are available and approval can be determined within ten minutes. For your convenience you can also apply online at www.carecredit.com

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist. If dentures, partial dentures, crowns and/or bridges, retainers mouth guards or night guards are to be fabricated by a dental laboratory, a 50% deposit will be required at time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserte The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist. Checks that are returned to our office from your financial institution are subject to a $30.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services.
We understand insurance guidelines can be difficult to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility. All insurance co-pays and deductibles must be paid at the time of service. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account.
Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims. We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts will be subject to a charge of 18% per month interest. I am responsible for all collection costs incurred by the dental office.

Regarding Appointments
Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment so we ask that you kindly give us a minimum of 2 business days' notice. Without this notice, we are unable to offer treatment to other patients that may have needed our care. If 2 or more appointments are broken in a 12 month period without 2 business days' notice, a cancellation fee of $50 will be applied to your account and if necessary, all future appointments will be cancelled and patients will be placed on a "priority list" for their next visit.

All of our patients are different and present with different needs. As such, we strive for optimal outcomes with favorable results but this is not always guaranteed.

By signing this Notice, you acknowledge that you received and understand this Notice and you accept the terms as indicated herein. A copy of the signed Notice will be maintained with your dental records and which will be provided to you upon your request.

_____
Patient Name

_____ Date: _____

Signature of Patient/Legal Guardian/
Authorized Representative