



Mitchell V. Sabbagh DMD, PC

www.AestheticDentistryOfNewYork.com

FINANCIAL POLICY

Dr. _____

Insurance _____

- In-Network** (Doctor is contracted with your insurance plan.)
- Out of Network** (Doctor is not contracted with your insurance plan.)

Payment is expected at the time of service. For your convenience, we do accept Master Card, Visa, Discover, and American Express. We ask our patients to give at least 24 hours notice if they must cancel an appointment. We reserve the right to charge your account a missed appointment fee of \$100.00. A \$25.00 returned check fee will be assessed to your account for all returned checks.

We will contact your insurance company for you and determine as close as is possible what your portion is to pay on the date of service. This information is an **estimate only** and we cannot guarantee any information to your insurance company on your behalf. After your insurance company pays their portion, we will inform you of what balance, if any, is outstanding for you to pay. This amount will be due upon notification.

Please note that your insurance policy is a contract between you and your insurance carrier. **It is your responsibility to understand your plan benefits.** If for any reason your insurance carrier does not pay within forty-five days, as allowed by law, the balance will become your responsibility. This balance will be assessed monthly interest charges of 1.9% if not paid upon receipt of your statement. In the unfortunate circumstance that your account becomes more than 90 days overdue we will send your account to Trojan Credit Services, our collection agency, your account will also be charged an additional collection fee of \$50.00.

Consent:

_____ I consent to the diagnostic procedures and treatment by the dentist necessary for proper care.

_____ I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

_____ I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

Our staff is available to answer any questions that you may have regarding our financial policy.

By my signature, I have read and understand the financial and consent policy of this office. If I request to enter into a payment plan or financing of any sort, I hereby give my permission to have this office retrieve a credit report on me. In cases where the payment is being received directly from the insurance company, I authorize payment to this office.

Signature _____ Date _____
(Parent or Guardian's signature required if the patient is a minor.)