Valerie A. Scola, D.D.S.

Financial Policy

We are happy that you chose us for your dental care. Please carefully read, initial and sign this agreement. Let our finance staff know if you have any questions:

Initial: _____ 1) We are happy to prepare the necessary forms to help obtain payment from your dental benefit plan, providing you give us all the information required to process your claims.

Initial: _____ 2) Patients are responsible for knowing their dental benefit plan. This includes, but is not limited to: eligibility, maximums, deductibles, co-payments, frequency limitations, and waiting periods. As a courtesy, we can help you verify dental benefit information. However, it is ultimately **your** responsibility to know what is covered under your dental benefit plan.

Initial: _____ 3) You will need to pay your portion of the charges as you go. This includes annual deductibles, co-payments, and charges your dental benefit plan refuses to pay. Any balance on your account remaining after we have received payment from your dental benefit plan is expected to be paid within 30 days.

Initial: _____ 4) Occasionally, a dental benefit plan payment will be sent to the patient. If this occurs, please bring us the check and the attached stub. The information on the stub is very important.

Initial: _____ 5) Patients without a dental benefit plan will be expected to pay for treatment on the date that services are rendered – **no exceptions**. Financing options are available through Care Credit or Lending Club. Please ask a staff member for more information if you are interested.

Initial: _____ 6) Account balances 60 days or older will be subject to a finance charge of 1.5% per month. Account balances over 90 days old will be referred to our collection agency unless prior arrangements have been made. All collection expenses are the account holder's responsibility.

Initial: _____ 7) If you suspend or terminate your care against the advice of your doctor, all outstanding charges that have not been paid by your dental benefit plan will become immediately due and payable by you personally before you leave.

By signing below, you acknowledge that you have read this policy and agree with the terms. Your signature below also assigns dental benefit plan payments directly to the dentist.

_____ _____

Patient Name (please print) Date

_____ _____

Signature (Parent/Guardian if patient is a minor) Relationship to patient