

**DENISE ACIERNO, D.D.S.
PAYMENT POLICY**

To Our Valued Patients,

The following information is provided to you to assure patient understanding and agreement concerning payment for professional services:

PAYMENT AT THE TIME OF TREATMENT – We ask that the patient pay for treatment at each visit. When the patient does so, the costs of billing and extending credit are avoided. These savings enable us to help minimize the cost of the patient's dental care. We will accept cash, checks, and credit cards (Visa, and Master Card).

DENTAL INSURANCE – As a courtesy to our patients with dental insurance coverage, we will:

- 1) submit an electronic claims for those services which may be submitted in this form; or submit a paper claim form to the insurer seeking reimbursement for services already provided (excluding BCBS) and;
- 2) follow-up one time with those insurers from which payment is not received.

If a payment is not received from the insurance carrier, the outstanding balance will be transferred to the patient's personal account 60 days after his/her visit.

PLEASE NOTE:

Dental insurance is an agreement between the patient's insurer and the patient. The patient is responsible for;

- 1) being aware of his/her contract maximums and claims outstanding against those maximums
- 2) paying for charges not covered by the claim
- 3) promptly paying for accounts not paid by the insurer.

Our practice is committed to providing the best treatment for our patients. Patients should be aware that some, and perhaps all, of the services provided may not be covered by the patient's dental insurance. We will make every effort to supply estimates to the patient for services to be provided. **Patients are responsible for payment regardless of any insurance company's determination of usual and customary fees.**

OVERDUE ACCOUNTS – Any account with an overdue balance will not receive future treatment until the previous balance is paid. Overdue accounts may result in collection procedures which may influence the patient's credit rating. All fees incurred to pursue collections are the patients' responsibility.

We believe that a good dentist/patient relationship is based upon understanding and open communications. We hope to avoid any confusion over payment for professional services. If you have any questions or need assistance, please feel free to contact us at (248) 548-6365.

I have read, understand, and agree with financial policy statement.

Patient Signature
(Parent Signature if patient is a minor)

Patient Name (please print)

Date