

Pure Dental Care
122 Courtyard Drive
Hillsborough, NJ 08844
908.218.7999

DENTAL OFFICE FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

GENERAL: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits are included in your policy. If you have any questions concerning the pre-treatment estimate and/or fees for service contact your dental insurance, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion. It is patients' responsibility to understand their policy and what will be covered.

PAYMENT: FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. Please indicate below the form of payment you wish to choose. We charge a \$50 return check fee. Late fee of \$10 will be added every 30 days for unpaid balance. Any balance left unpaid after 90 days without attempt at resolution will be considered for collection. A collection fee will be added to account if placed in collection.

- Cash or check
- Visa, MasterCard, Discover, Amex
- Care Credit
- If you qualify, a monthly payment plan is available for your convenience.

APPOINTMENT CANCELLATION POLICY

When we make your appointment, we are reserving a room for your needs. We ask that if you must change an appointment, please give us at least 48 hours' notice (we need two full working days' notice to cancel without penalty). **A \$75 charge will be made of failed or cancelled appointment without prior notification of 48 hours.**

If you have unsubscribed yourself out of our software confirming system, you are responsible to remember your scheduled appointment. These fees are not covered by insurance and is therefore the sole responsibility of the patient. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely dental care.

HIPPA Policy

I have read and acknowledged the Health Insurance Portability and Accountability Act (HIPPA) that was presented to me. A copy of this form is available those that would like one.

I acknowledge I have received and agreed to Pure Dental Care's Payment & Financial Policies.

Signature: _____ Date: _____