HEIGHTS DENTAL SMILES
HAPPY SMILES HEALTHY LIVES

Susanna N. Zilberman, D.D.S., P.C.

OUR FINANCIAL POLICY

Thank you for choosing our practice as your healthcare provider. Our office is dedicated to providing optimal care for every patient in the most economical way possible. The following is a statement of our financial policy. Please read it and let us know if you have any questions. We feel misunderstandings can be avoided when complete information is exchanged.

OPTIONS FOR PAYMENT OF TREATMENT:

1. **Non-Insurance Patients**: Payments is expected at the time of service for treatment performed that day unless prior arrangements have been made. For your convenience, we accept cash, personal checks, money orders, and all major credit cards.

2. **Insurance Patients**:

- We will file an insurance claim on your behalf as a courtesy to you; however, you must supply, prior to treatment, all the necessary information for filing.
- Any deductible as well as any estimated percentages your insurance does not cover, are to be paid on the date of treatment.
- It is the patient's responsibility to know the details of the insurance coverage, including percentages payable, waiting periods, deductibles, yearly maximums, services not covered under the plan, and any other related information.
- If your insurance company has not paid their liability in full within 60 days, the balance then becomes, the patient's liability.
- For patients whose insurance company pays them directly, payment is expected on the date of treatment
- Your insurance policy is a contract between you and your insurance company and the financial responsibility for your treatment is yours whether the insurance company pays or not.

3. Finance charges of 1.5% per month will be applied to balances over 60 days old.

4. Long term payments may be available. We have information on several companies that offer this service and we can help you with details.

Each time a patient misses an appointment without providing proper notice (at least 24 hrs), another patient is prevented from receiving care. Therefore, Heights Dental Smiles reserves the right to charge a fee of $50.00 for all missed appointments.

I HAVE READ THIS FINANCIAL POLICY AND UNDERSTAND AND AGREE TO THE TERMS OF THIS POLICY.

Patient Signature:_____ (SEAL) DATE:_____

I allow for release of my x-rays and records to my insurance company as needed for proper processing and payment of my dental claims. I allow for release of my x-rays and records to other dental specialists, as needed, for my dental care. I also allow for photograph to be taken of my mouth and dental work as a record of progress of my treatment.

Patient Signature:_____(SEAL) DATE:_____ _