

John N. DiStefano Jr. D.M.D.
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Office Financial Policy- Informed Consent

Thank you for selecting our office to care for your dental needs. We are committed to your treatment being successful. Please understand that payment of any fees incurred is considered part of your treatment. We feel it is important for you to have a clear understanding of your financial commitment to our office.

Please note that payment by cash or check is expected at the time services are rendered. Visa and Mastercard are also welcomed. Arrangements can be made to make necessary treatment affordable, however these must be discussed prior to the beginning of treatment.

Regarding Insurance: If you have dental insurance, it should be understood that this is an agreement between you and your insurance company. Dental treatment and resulting fees are an agreement between you and your doctor. You are entirely responsible for the payment of your entire bill regardless of the status of your insurance claim. If you have insurance coverage we will estimate your patient portion and the expected insurance portion. This is done by using the percent of coverage your policy allows for certain procedures. We will expect the estimated patient portion to be paid at the time of the visit. As a service to you, we will electronically file an insurance claim and wait for the estimated insurance payment. If for any reason the insurance company does not pay their expected portion, we will bill you for the non-covered amount.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and our fees reflect our level of care and skill. They are well within the usual and customary charges for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Unusual Circumstances: Should a situation arise that makes it impossible for you to meet our credit terms, we invite you to call or personally discuss the matter with our office staff. This will avoid misunderstandings and enable you to keep your account in good standing. Except when hardship warrants otherwise, or other arrangements have been made, accounts over 90 days past due are referred to a collection agent.

Missed Appointments: Time is very valuable. When you schedule an appointment, that time is reserved for you. If you are unable to keep an appointment we require 24 hours notice. This allows us to offer the time to another patient. We reserve the right to bill our patients a normal office visit rate for broken appointments when no, or late, notice is given.

Consent:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account and I will be held responsible for any charges that are the result of collection activity.
4. I have received a copy of this office's Notice of Privacy Practices.

Patient Signature _____ Date _____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not due to ____ refusal to sign ____ Communication barriers ____ Other