FINANCIAL POLICY

☐ **Dr. Mitchell V. Sabbagh,** Out of Network is not contracted with dental insurance carrier

Insurance Carrier: _____ Max: $_____/ Ded: $_____ P _____%, B _____% M _____%
For majority of Delta policy holders, treatment payment option 1 applies.

☐ **Dr. Karen B. Erani,** In Network is contracted with your dental insurance carrier

Insurance Carrier: _____ Max: $_____/ Ded: $_____ P _____%, B _____% M _____%

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in obtaining your dental benefits. You (not the insurance company) are responsible for the fees of services rendered. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.

Treatment Payment Options:

1. ☐ *Pay In Full on Date of Service, Insurance Assignment of Benefits to Patient or No Insurance*

2. ☐ *Pay Estimated Co-Payment at time of Treatment with Credit Card on File*

We will accept insurance assignment of benefits to reduce your *immediate out-of-pocket expense*. Because we cannot guarantee exact insurance coverage, there may be a balance remaining after insurance payment is received. At which that time your credit card on file will be charged the remaining balance.

I hereby authorize ADNY to charge my credit card on file. I agree to option 2 as selected above. I guarantee that I am the legal cardholder for this credit card account and that I am legally authorized to use it.

Option 2 Signature Required:_____/ Date:_____

Upon request we may submit a pre-treatment estimate for you and determine as close as it is possible what your portion is to pay on the date of service. This information is an **estimate only.** The insurance relationship constitutes an agreement between the carrier and the patient. As such, we cannot make any guarantee of estimated coverage or payment.

If for any instance your patient balance exceeds 60 days it will be assessed monthly interest charges of 1.9%. In the unfortunate circumstance that your account becomes more than 90 days overdue we will send your account to our collection agency. Your account will also be charged an additional collection fee of $50.00.

We ask our patients to give at least 24 hours' notice if they must cancel an appointment. ***If you fail to give 24 hours notice, We reserve the right to charge your account a missed appointment fee of $100.00.*** *A $25.00 returned check fee will be assessed to your account for all returned checks.*

Consent:

_____ I consent to the diagnostic procedures and treatment by the dentist necessary for proper care.

_____ I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

_____ I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

We are available to answer any questions that you may have regarding our financial policy.

By my signature, I have read and understand the financial and consent policy of this office. If I request to enter into a payment plan or financing of any sort, I hereby give my permission to have this office retrieve a credit report on me. In cases where the payment is being received directly from the insurance company, I authorize payment to this office.

Patient Name:_____

Signature:_____ Date:_____
(Parent or Guardian's signature required if the patient is a minor.)