Family and Esthetic Dentistry of Hamden, LLC
2559 Dixwell Avenue Hamden, CT 06514

FINANCIAL POLICY

Thank you for choosing us as your dental care providers. We are committed to providing you with the highest quality, state-of-the-art dental care. With this in mind, we offer several different options to make your dental care comfortably affordable.

FORMS OF PAYMENT and BALANCES DUE

You may choose from any of the following (including any combination thereof): Cash, VISA, MASTERCARD, American Express, Discover, Money Order, Personal Checks, or Care Credit (outlined below).

FINANCIAL OPTIONS

1. **FULL PAYMENT:**
   All our patients who pay their entire fee in full AT THE TIME OF SERVICE with either cash or check will receive a 5% courtesy that will be deducted from the total patient obligation (not from any portion due from insurance companies).

2. **ESTIMATED INSURANCE CO-PAYMENT:**
   We will accept assignment of insurance benefits. As a courtesy to our patients, in addition to submitting your dental claim, if you prefer, we will initially ask you *only for your **estimated** co-payment*. Please understand that this is only an ***estimate*** and is based solely on information provided to us. It is each patient's individual responsibility to ensure that we have current and accurate insurance information so that we may file claims on your behalf. If for ***any reason***, we have not received your insurance carrier's payment **90 days** after the claim, the remaining balance will be due and payable by **YOU** upon receipt of our statement.

3. **DENTAL FEE PLAN PAYMENT:**
   With a short application and fast approval over the phone from Capitol One, we can establish longer-term payment plans for treatment over $300 than we could offer in our office. In many cases, the terms are interest free to patients if paid within a given period of time. There is no prepayment penalty. We will gladly assist you in contacting them from our office.

4. **CUSTOMIZED PAYMENT PLAN (for extensive treatment ONLY):**
   For our patients with extensive amounts of treatment to be performed, we may offer payment arrangements on an individualized, per-treatment basis. Patients participating in these plans must consent to a written, signed financial plan **PRIOR** to the initiation of treatment. Terms and method of payment will be arranged through our financial coordinator and outlined in a written agreement.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing only superior dentistry. As a result, we are proud of our fees and feel they are a fair reflection of the high quality and service we provide. We cannot be held responsible; however, for an insurance carrier's arbitrary determination of usual and customary fees. **The range of your insurance benefits depends solely upon what your employer wishes to purchase.** It is your right to know what our fees are for any procedure we recommend. We will attempt to always review the costs for procedures prior to the beginning of treatment.

DEPENDENT/MINOR PATIENTS

The adult **accompanying** a minor child and the parent(s) or guardian(s) of the minor child are responsible for the full or insurance co-payment AT THE TIME OF SERVICE.

INSURANCE

Your insurance policy is a contract between you, your employer, and your insurance carrier and therefore, is responsible ONLY to you and your employer and NOT to our office. We will assist you in any way we can to ensure you receive the maximum insurance benefits you are entitled to, but ultimately, YOU will be responsible for payment for any and all services rendered whether or not the insurance company chooses to pay. If you have any questions or concerns regarding this policy, we will be happy to assist you.

I have read, understand, and agree to the terms and limitations outlined in this policy.

X_____ Date_____

Signature of Responsible Party