Vicaretti Dental Care 139 Spencerport Rd, Rochester, N.Y (585) 429-6943

Office Financial Policy

We feel it is your right to have a clear understanding of your financial commitment to our office. We offer the following information to help make necessary treatment affordable to you. Insured and uninsured patients are requested to make arrangements keeping in mind the following:

- Payment for services is expected at the time of treatment. We accept; Cash, Visa, MasterCard, Care Credit, and personal checks for your convenience. If the bank returns a check, the account will be charged a service charge. Assignment of insurance benefit is accepted if a completed form is brought to the office and any co-pay or deductible is paid.
- A 5% courtesy allowance on professional services is extended for a cash or check payment of the total bill (accounts over **$100 only**) when paid at the time of service.
- A 5% courtesy allowance for professional services is extended to **senior citizens 65 years of age or older, with no insurance.**
- For your convenience, you can sign an **Authorization Card** to be used for any unpaid balance remaining **after** your insurance benefit has been received and receive a **5% courtesy** on the balance you owe.
- AN APPOINTMENT NOT KEPT WITHOUT 24 NOTICE IS SUBJECT TO A BROKEN APPOINTMENT FEE.

Extended payment plans are available upon approved credit. **There is no interest or carrying charge with payments remain current; however, all balances are subject to a billing charge of $10.00 per month when your account is not kept current.** Occasionally, situations arise that may prevent you from making payments to this office on schedule. **To avoid a misunderstanding please notify us** IMMEDIATELY so that we may help you avoid the monthly billing charge.

If your insurance company has not made payment within **90 days** of billing, the balance will become the responsibility of the patient. Please remember that insurance is an agreement between you, your employer and the insurance company. Therefore, if any problem arises with the carrier, we will ask that handle it with the insurance company. Our office will provide your insurance company with any additional information, which may be necessary for resolution. Dental insurance has **partial coverage** for services and an estimate insurance benefit is an estimate. THEREFORE, WE MUST LOOK TO THE PATIENT AS THE PERSON RESPONSIBLE FOR PAYMENT.

Assignment of Benefits & Release of Information

I authorize payment of all dental, medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other health plans to: **Dr. John P. Vicaretti Dr. Bernadette Marino**

This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize and assign to release all information necessary to secure the payment of said benefits.

Signature_____ Date_____

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 29% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I have read and understand the above financial policy.

Name of responsible party_____ Date_____

Witness_____ Date_____