

FINANCIAL POLICY

Patient Name: _____ Birth Date: _____ Date: _____

The following is a statement of our financial policy. We ask that you read and sign prior to treatment.

Thank you for choosing the offices of Perry E. Rossino, D.D.S. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is to make the cost of optimal care as easy and as manageable as possible for our patients. We do this by offering several payment options.

We will accept almost all dental benefit plans. ***We require your co-insurance and deductible to be paid in full at the time of your visit.*** The balance is your responsibility. As a courtesy to you, we will process your insurance claims, without an additional fee. It is your responsibility to inform us of any changes in your benefit coverage. Your dental benefits are a contract between you and your employer's choice of benefit company. Please note, that we are not a party in the contract between you and your employer's benefit company. Also be aware that although we will verify your coverage, some and perhaps all of the services provided may not be covered under your policy. We will **ESTIMATE** your co-insurance based on the information obtained from your benefit company. Often times what is quoted by your benefit company is not what is actually paid.

All accounts are due in full when services are rendered. To accommodate you, we accept cash, personal checks, and all major credit cards. For extensive treatment plans, we offer monthly payment plans from CareCredit*.

A fee of \$50 is charged for patients who miss or cancel more than one appointment in a calendar year without 24-hour notice.

A fee of \$30 is charged for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

Patient/Guardian Signature: _____ Date: _____

* CareCredit is subject to credit approval. Please see an office receptionist for details.