My Saratoga Dentist PLLC
569 N Broadway
Saratoga Springs, NY, 12866
(518) 584-9172

FINANCIAL AND OFFICE POLICIES

Our practice is committed to providing you with professional treatment and personalized care. We ask that you carefully read and sign this statement, which outlines our policies regarding payment, insurance claims and scheduling.

PAYMENT

You are responsible for full payment at the time of service. Full payment may include partial coverage from your insurance carrier, but the details must be arranged prior to "major treatment" (see insurance coverage below). We accept cash, checks, VISA and Mastercard. We reserve the right to charge interest on balances over 30 days at a rate of 1.5% per month. There is a $25.00 service charge for returned checks. The patient will be responsible for any collections or attorney fees should an account become delinquent.

INSURANCE COVERAGE

It is your responsibility to know the definition of your unique insurance plan, since some of your treatment may not be covered under its terms. It is possible to submit a "pre-authorization" for any "major work" you may require, in order to accurately determine We will be happy to answer questions when possible & submit all forms on your behalf.

Assignment of benefits. Assignment simply means that you agree with your insurance company to allow them to send the sum assigned by your coverage directly to us. We still require payment from you at the time of treatment for any balance not covered by your insurance plan, this includes any deductible.

Our relationship with your insurance company. Please understand that your insurance coverage is an agreement between you, your employer, and your insurance company. We are not part of this contract. Please be aware that insurance policies and claims do not always cover full payment. We do our best to estimate your portion at the time of your visit; however this is only an estimate. The balance will be your responsibility.

Late payment. If you have an outstanding balance on your account or your insurance company has not paid within 60 days, the outstanding balance may be transferred to your credit card retainer or to your personal account.

GHI, Teamsters, Military Retirees, and possibly other insurances. Please note that these insurance companies do not accept assignment of benefits from us, therefore you will be responsible for full payment at the time of treatment and prior to submission of insurance claim forms.

"Usual and customary" charges. Our practice is committed to providing the best possible treatment to our patients and we charge what is usual and customary in this area. You are responsible for full payment regardless of how your insurance company arbitrarily determines what it claims to be "usual and customary" rates.

MISSED APPOINTMENTS

Unless cancelled at least 2 working days in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Your appointment is confirmed at the time it is made. We make an effort to contact you with a reminder as a courtesy; but, you should not depend solely on this as it may not always be feasible to get through. Longer appointments may be offered to you as a matter of convenience – especially for surgical, restorative, or esthetic procedures involving adjacent teeth and/or requiring uninterrupted attention. Reserving such longer appointments may require a deposit that is non-refundable if broken or cancelled without 2 working days notice. Please help us to keep costs down, and to serve you better, by keeping your scheduled appointments and promptly notifying us of any changes.

CONFIRMATIONS

As a courtesy, our office makes an attempt to contact you to remind you of your scheduled appointments. We acknowledge that it is not always possible to reach you by phone, so it is important that you keep track of your appointments and contact us in accordance with the policy outlined above. We strongly advise that you provide us with (and update) alternative contact information to facilitate reaching you when necessary. Please indicate alternative contact information below:

I have read the above and understand and agree to this policy.

Name:_____
(please print)

Signed:_____Date:_____

Credit Card #_____ _____ _____ _____ Exp_____/_____ CVV code _____