Boulevard Dental Associates P.C.

Financial Policy

Our financial arrangements are based on an open and honest discussion of treatment options, respective fees and patients' financial capabilities. Dr. Medianick and our staff are dedicated to serving your dental needs with the best professional advice, care and service possible.

Private Pay Patients

Payment is expected in full at the time of service unless prior arrangements are made. We offer several payment options:

- Cash
- Checks
- Visa, MasterCard, Discover, or Debit
- Care Credit (6-12 months interest free financing) for balances of $700 or more

Insurance

Our office is committed to helping patients maximize their insurance. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a courtesy to our patients, we are happy to manage all claim submission, but this in no way relieves you from the responsibility of your bill. *It is your responsibility to know your insurance policy rules and benefits.* We cannot render services on the assumption that the charges will be paid by your insurance company. We will however, help in every way we can in processing follow ups, queries, lost claims, etc., on your behalf.

Missed Appointments

Appointment time is reserved exclusively for you. *We do not double book appointments because Dr. Medianick believes you deserve his undivided attention.* By giving 48 hours notice of appointment changes or cancellations, other patients who need our time and care can be appointed. If 48 hours notice is <u>not</u> given, a $60.00

charge will be billed to your account. This charge is not covered by your insurance.

Service Charges
Non-Sufficient Funds Check fee is $40.00. A monthly charge of 1.5% will be applied to any balance over 90 days.

I understand and agree to this financial policy. I understand that regardless of what insurance coverage I have, I am ultimately responsible for the timely payment of my account.

_____
Patient Name(s) (please print)

_____
Responsible Party Name (please print)

_____ _____
Patient/ Responsible Party Signature Date