CAMBRIDGE DENTAL
MARK A. GAONA, D.D.S

Cambridge Dental Office Policy / Financial Policy

My staff and I welcome you to our practice and thank you for choosing us for your dental care.

Please carefully read and sign the following statement of our financial policy. Feel free to speak to our office staff if you have any questions.

The patient or the guarantor is responsible for payment of services that are rendered. If we are a "Preferred Provider" on your Insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. You will be responsible for all coinsurance and deductibles on the day of service. If a procedure is generally deemed to be "cosmetic" we do not bill insurance directly. You must pay for the procedure in full and we will provide you with the necessary paperwork to submit to your insurance company on request.

IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS.

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If we do not receive payment within 60 days, the patient will be billed. If you are unclear of you insurance benefits, please contact your carrier for clarification of coverage. For your convenience, we accept **VISA, MASTERCARD, CASH AND CHECK.** Alternative financing through a third party is also available.

Delinquent accounts over **90** days will subject to the following action: A collection processing fee will be added to your outstanding balance and will be turned over to a separate agency for collection.

There will be a **$25.00** service fee for all returned checks. NSF checks must be redeemed with certified funds (**cashier's check, money order, certified check or cash**).

If you need to cancel an appointment, please contact our office at least **24 hours** before your appointment time. Because of high demand for appointments, missed appointments prevent us from seeing other patients that may be in urgent need of dental care**. A $50.00 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 24 HOUR ADVANCE NOTICE.**

It is your responsibility to notify our office if there is a change in your insurance coverage, address, or phone number.

I have read and understand the above Financial Policy and agree to abide by its terms.

_____ _____

Signature Date