

Marina Pinkas, D.M.D.
Aesthetic Dental Associates

Patient Name: Last Name First Name Middle Initial

Our Financial Policy

Thank you for choosing Marina Pinkas, D.M.D. and Aesthetic Dental Associates for your dental care. We are committed to the success of your dental health and treatment. Please understand that paying your bill is part of the process. It is important that you understand the following items:

1. You are responsible for all charges incurred. Based on your insurance benefits, all co-pays are estimated. If the insurance overpays, we will credit your account. If the insurance underpays, we will bill you. Eligibility of insurance does not guarantee payment. Payment is ultimately your responsibility.
2. **Co-pays must be paid at the time of your visit.** We accept cash, checks, VISA, Master Card, and Discover. We also accept Care Credit, a long term financing alternative.
3. **If your insurance fails to pay within 60 days from the date of service, we will collect payment from you, and you should be reimbursed from your insurance company.**
4. You will be assessed a fee of \$25 for reprocessing checks that are returned for insufficient funds.
5. Unless prior arrangements have been made, your account will be turned over to a collection agency if you fail to pay within 90 days from the date of service.
6. Patients under the age of eighteen (18) will not be seen unless accompanied by a guardian or unless we receive a signed authorization consenting to full treatment of your child.
7. It is the patient's responsibility to show up for their scheduled appointment, or call and cancel with 24 hours notice. **There will be a \$51 charge for failed appointments.** We reserve the right to charge for less than 24 hour notice of cancellation. **AS A COURTESY ONLY**, we try to call to remind patients of their appointments; however, it is the patient responsibility to keep track of all scheduled appointments.
8. Your scheduled time is important to complete your dental work. If you arrive more than 10 minutes late, we may reschedule your appointment.
9. The **patient is responsible** for knowing their dental insurance coverage, including the number and frequency of the allowed cleanings per year. Some people require more frequent cleanings.

I have read, understand and agreed to the financial policy of this office. My signature indicates that I understand and agree to comply with this policy

Signature

Date