Princeton Park Dental Associates

Financial and Appointment Consent Form

We welcome you and your family to Princeton Park Dental Associates. We ask that you review and complete our office and financial policy consent form to provide you with the most beneficial and comprehensive services and care. We will gladly discuss your treatment plan, financial options and any other questions you may have.

Dental Insurance

If you have dental insurance we will file the claims for you as a courtesy**. Please remember that your insurance benefits are a contract between you and your insurance company, not our office.** We do ask that you provide us with the correct insurance information at the time of your appointment in order for us to timely file the claim and collect insurance payments. All insurance payments will be allocated in accordance with network participation and state law. Our office will provide you with an approximation of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are only estimates and not a guarantee of insurance payment. Insurance pre-authorizations may be completed to verify coverage and benefits but are subject to your insurance's disclaimers. Please note that any difference in payment from the insurance company is your responsibility. All unpaid insurance balances remaining after 90 days from the date of service becomes the immediate responsibility of the patient and/ or account holder.

Payments / Copays / Fees

Payments for copays and/ or deductibles are due at the time the services are provided. We accept payments in cash, check, credit cards and CareCredit. CareCredit is a bank financed option for qualified applicants who prefer additional time to pay their balances.

Account Balances / Charges / Fees

Any balance older than 90 days will be subject to interest charges of 2% (approximately 27% annually) per month until the account is paid in full. If balance is not paid in full after 90 days, the account will be sent to a collections agency. Any attorney or administrative fees incurred due to delinquency in payment will also be charged to the patient. Any personal check returned unpaid or with nonsufficient funds will incur a $35 return check fee.

Cancellations and Broken Appointments

We respectfully request a 48 hour cancellation notice. Your scheduled time has been saved only for you and the doctor and/ or hygienist. If less than 48 hour notice is given for appointment a non-refundable cancellation fee of $100 will apply.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction.

_____

Patient's name

_____ _____

Signature of Patient/Guardian Date