BARRY P. LEVIN, D.M.D. FINANCIAL POLICY

Patient Name_____ Responsible Party_____

Thank you for choosing us as your health care provider. We are committed to providing the best possible treatment for our patients. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

*** FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE.
*** WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.
*** WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL
*** INTEREST OF 1.5 % IS CHARGED MONTHLY ON ALL BALANCES OVER 60 DAYS

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INSURANCE BENEFITS: We cannot submit a claim to your insurance company without the proper information. In the case where your insurance company requires a claim form, we also ask that you bring a completed and signed form. If you change your insurance company or if your insurance company changes its forms or procedures or imposes additional or different requirements in the future, you will provide all necessary information and sign all appropriate documents. Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best possible treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any arbitrary determination by your insurance company of what is usual and customary. Unless we are participating with your insurance plan, we require that all co-payments and/or deductibles be paid at the time of services unless other arrangements have been made.

MINOR PATIENTS: The parent/guardian accompanying a minor child is responsible for payment.

***MISSED APPOINTMENTS*:** **SURGERY APPOINTMENTS REQUIRE A MINIMUM OF FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION. IN THE ABSENCE OF ADEQUATE NOTICE, A CHARGE OF 30% OF THE ANTICIPATED FEES WILL BE INCURRED. HYGIENE APPOINTMENTS REQUIRE A MINIMUM OF TWENTY-FOUR (24) HOURS NOTICE OF CANCELLATION. IN THE ABSENCE OF ADEQUATE NOTICE, A CHARGE WILL BE INCURRED FOR THE FULL FEE.**

LEGAL ACTION: If it were to become necessary to take legal measures to satisfy a delinquent account, all legal and court expenses would be added to the balance due.

I have read and understand this Financial Policy, and I agree to be bound by its terms.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Visa, Master Card,Discover or American Express Card # Exp. Date