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Family and Cosmetic Dentistry
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Financial Policy

This is an agreement between Dr. Daniel Schwartz or associate, as creditor, and the patient named on this form.

In this agreement the words **"you," "your," and "yours"** mean the patient. The word "account" means the account has been established in your name to which charges are made and payments are credited. The **words "we," "us," and "our"** refer to Dr. Daniel Schwartz or associate.

By signing this agreement, you are agreeing to pay for all services that are received.

Payment options if you have no insurance are as follows:

A: You choose to pay by _____cash, _____check, or _____ credit card on the day treatment is rendered.

B: On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and the balance on completion date.

C: We offer special financing through Care Credit or Citi Bank. No interest charges if paid within 3, 6, or 12 months. This includes an additional merchant's fee percent.

Payment options if you have insurance are as follows:

A: you choose to pay your deductible of $ _____ and any out of pocket portions at the time that services are rendered by ____cash. _____check or _____ credit card.

B: On extensive treatment (crowns, bridges, dentures) you may choose to pay 50% of your our out of pocket portion on the start of preparation date and this balance on the completion/delivery date.

Insurance: Insurance is a contract between you and your insurance company. In most cases, we are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we **ESTIMATE** what your insurance company may pay the insurance company that makes the final determination of your eligibility. **You are to pay any portion of the charges not covered by insurance.**

Required payments: Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement; therefore, we cannot bill you for these.

Returned checks: There is a fee ***(currently $25)*** for any checks returned by the bank.

Missed appointment fee: Patients who do not show up for an appointment Monday – Friday, or cancel with less than 24 hour notice will be charged a $35 fee. This fee must be paid before the new appointment is scheduled. The second time this occurs, a $50 fee will be charged. Patients with three missed appointments will be asked to transfer their records to another doctor. Appointments missed on Saturdays will be charged a $70 fee.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay us all of the collection costs and late fees which occur. If we have to refer collection of the balance to a lawyer you agree to pay all of the lawyer's fees plus all court costs.

Wavier of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have litigate in court, or if your past due payments are reported to a credit agency, the fact that you received treatment in our office may become a matter of public record.

Divorce: In case of a divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the patient authorizing treatment for a child will be responsible for the charges. If the divorce decree requires the other parent to pay any of the treatment costs, it is the authorizing parent to collect from the other parent.

Transferring Records: You will need to request in writing, and pay a fee (currently $35) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive relevant information, including your payment history.

Effective date: Once you have signed this agreement, you agree to all of the terms contained herein and the agreement will be in effect.

Patient's name: _____ **Responsible Party(if not the patient):**_____

Signature: _____ **Date:** _____

Co-Signature: _____**Date:** _____