Financial Policy

Welcome to the practice. Please read, understand, and accept the financial policies, as described below.

We will bill your dental insurance company for any services provided. Any required co-pays or deductibles owed by you will be collected at the time of service, unless other arrangements are made prior to your appointment.

For your convenience we accept the following methods of payment: cash, check, Master Card, Visa, Discover, and American Express, and Care Credit.

It is understood, and agreed, in the event your insurance company does not pay an outstanding balance, you are personally responsible for the payment of all charges due. In addition, if your insurance company has not paid the submitted charges within 60 days, you will be responsible for the amount charged and will pursue payment yourself by contacting your insurance company directly.

It is the patient's responsibility to know their insurance coverage and maximums. We are not responsible for any services not covered under your insurance contract.

Our office participates with Excellus Blue Cross Blue Shield. We are considered out of network with all other insurance companies.

A $50.00 fee will apply for all returned checks, in addition to the amount originally owed.

If you fail to notify the office of a cancellation 24 hours prior to a scheduled appointment, you are subject to a $50.00 missed appointment fee. The fee may be waived in case of an emergency. This must be paid prior to any future appointments.

You are responsible to pay any billed amount upon receipt of a statement. Any outstanding amount is subject to a 1.5% monthly finance charge when not paid upon receipt. Failure to pay any outstanding bill is subject to be sent to our collection agency. It is understood that you will be responsible for any fees charged by the collection agency, with any additional fees charged by the collections agency added to the original amount owed. You are responsible for any and all costs incurred including, but not limited to attorney fees.

I have read and agree to the terms of the financial policy described above.

Signature Printed Name Date

I am dedicated to providing you with the best care and service possible. Thank you for accepting responsibility for prompt payment. Thomas J. DeStefano, D.M.D.