LONG ISLAND DENTAL EXCELLENCE

Financial Agreement

We are committed to providing you with the best care possible, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial options is important to our professional relationship. Please ask any questions about our fees, financial options or your responsibilities.

Full payment is due at the time of each visit. If treatment will be rendered over several visits, payment can be made over the course of treatment. Payment in full is expected at the completion of treatment.

We are sensitive to the fact that some patients may not be able to pay cash for their treatment; therefore we do offer several alternative payment programs for your convenience.

1. Cash or check
2. MasterCard/Visa/American Express/Discover
3. Monthly payment plan through Care Credit or Springstone. Interest-free payment plans are available up to 12 months. Low monthly payment plans from 18-60 months are also available.

Regarding Insurance

If you have dental insurance, we will be happy to help you maximize your benefits. We will accept assignment of benefits as partial payment on large cases. The total fee charged is **your obligation.** We will keep credit card authorization on file to be billed at the time insurance payment is received. If your insurance carrier has not paid within 60 days following a claim, the entire balance will be charged to your credit card. Insurance is a contract between you and the insurance carrier. We are not a party to this contract. If you have a secondary insurance carrier we will be happy to file the claim on your behalf after the primary has been received. All assignments of secondary benefits will be paid directly to the patient.

Any outstanding balances over 60 days will be subject to a 2% monthly interest charge and a $25 fee will be charged on all returned checks. I/we will incur collection costs and/or reasonable attorney's fees for any delinquent balance placed with an agency or attorney.

I have read and understand the above financial options and agree to be responsible for my account as outlined.

Responsible Party Signature: _____

Patient Name: _____Date: _____