JOHN RAVERA, DDS
GENERAL & COSMETIC DENTISTRY

OFFICE FINANCIAL & DISCLOSURE POLICIES

Any financial arrangements must be made in advance. All emergency dental services performed without previous financial arrangements must be paid in full at the time services are rendered. **A $50 Missed Appointment Fee will be charged for appointments broken or cancelled without 24 hours notice.**

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she, not the insurance company, is personally responsible for payment of all dental services. Your insurance policy is a pre-determined arrangement between your employer and the insurance company. We are not a party to that contract. This office will help prepare and submit the insurance forms for our patients and assist in making collections from insurance companies and will credit any such collections received to the patient's account. Any co-pay quoted from this office is an estimate only, not a guarantee of coverage. Unfortunately, insurance benefits will almost always be less than anticipated. It is your responsibility to contact your insurance to determine your particular benefits or requirements. This dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

I understand that I will be responsible for a $25 fee for any returned check. In the event that full payment for charges incurred in my dental care is not made, I agree to pay all costs of collection, including a Collection Agency Commission of up to 45% and interest rate of 18% per annum. I further agree to pay all costs and reasonable attorney fees if a suit is instituted hereunder to collect monies owed by me. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency should collection procedures as described become necessary.

I grant permission to this office to telephone or email me at home or at my workplace to discuss matters related to my treatment. I also agree to let this office leave messages concerning appointments and/or results on my answering machine, with a family member, or by email.

I acknowledge that I have received or declined a copy of the office's Privacy and Office Policies.

_____
Name of Patient (PLEASE PRINT)

_____ _____ _____
Signature of Patient, Parent or Guardian Date Relationship to Patient

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