Forest Hills Dental, PC
102-10 66th Road, Suite 1 D
Forest Hills, NY 11375
718-275-9792
www.foresthillsdental.com

OFFICE POLICIES:

Payment Option:

Forest Hills Dental, PC strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. At the onset of your treatment, we will provide you with an estimate of your total treatment costs.

Please, understand that this will only be an ***estimate***. Should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Be assured that we will notify you of fee changes and obtain your approval to proceedings with the treatment. Please take a moment to review the financial options offered and indicate your choice of payment.

Plan A (Private clients ONLY): Payment in full on each day of visit with credit, cash, check, or debit card. We gladly accept MasterCard, Visa, Discover, or American Express. The 5% reduction of fees also applies to returned payments received by credit or debit cards on the day of service. Also, we are pleased to offer our patients another extended monthly payment plan option through Citi Health Card. Please see our Front Desk coordinator prior to treatment for more details and to receive a loan application.

Plan B: Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance carrier. Regardless of coverage, your estimated co-payment is due in full for the day of the treatment if your insurance carrier does not provide 100% coverage. We often offer our patients to leave their credit card number to use it for the part they are responsible as a difference in the fee not paid by the insurance company. In the unfortunate event that an insurance payment is not received within a 90 day period, you will be billed for the outstanding balance. Please, note that a $45 fee will be charged for all returned checks.

I have chosen option (.....) and accept full financial responsibility for this account and for the dentistry performed upon my dependents in this dental office. I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I am aware that if I have an outstanding balance that is not satisfied within 90 days than my account will be sent to the collection agency with an additional 40% collection fee. Legal fees will be applied to the account in case of dispute. Be aware that if your balance is past due for 30 days interest fee of 1. 5 % will be added to the amount.

Citi Health Card or Credit Card users:

If you have a Citi health card account, you are required to provide two forms of photo Identification, and the signature you provide at the end of this form allows our office to charge your account for completed work, co-pays, deposits for future procedures (especially irreversible ones), and past due balances. We will still send you a receipt in the

mail of your payment. If you choose to send payment via other method (cash, check) you must contact our office before your bill is due so we will not charge your account. If by the due date, we do not receive any payment you authorize us to charge your credit card or citi health card without you being present in our office.

Regarding 3D catscan x-rays and Full Mouth/ Recall/ Bitewing x-rays:

Please be advised that there is an $85 fee (free if x-rays are sent directly to other doctors via mail or email) for providing patients all x-rays with the exception of the 3D cat scan x-rays. If 3D cat scan x-ray is paid in full, the patient has the right to have one copy of the image. Any additional copies will be subjected to a $100 fee.

Please choose an option(s) most convenient for you to settle you account in full on the date when the service(s) provided:

- Visa Acct. # _____ Exp Date_____ Sty Code _____
- MC Acct. # _____Exp Date_____ Sty Code _____
- AMX Acct.#_____ Exp Date_____ Sty Code _____
- DISC. Acct.# _____ Exp Date_____ Sty Code _____
- Cash

* Speak with a front desk coordinator about in office financing plans.

Broken Appointments:

Broken appointments and cancellations within a 48 hour period will be subject to a cancellation fee of $150 or $100 per hour for any major work scheduled. If you come to your appointment also without having the payment for the appointment and decide to cancel it when you are at the office, the cancellation fee will still apply since we were notified less than 48 hours, so please do your best to call us ahead of time if you are not able to keep that appointment.

We use electronic reminders system to confirm your appointments scheduled at our office. It means that you may be confirmed through a few different options: at your home or work phone number, at your cell phone via text message, or by e-mail. It is our priority to see you at the scheduled time therefore it's ***very*** important for us to have your appointment confirmed. With the respect to our office and other patients, we ask you to confirm your appointment with our desk coordinators when messages are left. We appreciate your understanding. Please, let our front desk coordinators know what options suits your best:

Assignment and Release:

I herby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentist to release any information for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the services rendered to me by this dental office I am **obligated** to pay said office in accordance with its credit terms and policy.

I consent to the making of **videotapes, photographs, and x-rays before, during, and after treatment**, and to use of same by the doctor in scientific papers and demonstrations.

I certify that I have read or had read to me the content of this form and do realize the risks and limitations involved.

Client's Signature: Today's Date:

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