PITTSFORD family DENTAL

It all starts with a smile…pass it on!

Office Financial Policy

In an effort to prevent any misunderstanding, we have set forth this financial policy.

1. Full payment is expected at the time of service unless other arrangements are made.
2. When major services that involve lab work are performed (i.e. crowns, onlays, dentures, etc.), 50 percent is due upon preparation, and the balance is due upon insert.
3. A service charge of 1.5 percent per month on the unpaid balance will be charged after 30 days.
4. If an appointment is broken or cancelled with less than 24 hours notice, a charge of $25.00 will be applied to your account.
5. Returned checks are subject to a $20.00 service charge.
6. It is understood and agreed that in the event that any outstanding balance has to be referred to a collection agent or attorney for recovery, the patient will be fully responsible for any costs, including but not limited to attorney's fees.

Name of Responsible Party _____ Social Security # of Responsible Party _____

Please list full name of each family member that you are responsible for:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please fill out the following information if you have Dental Insurance

(Make sure that all information is complete. It will greatly expedite the processing of your claim. Thank you.)

Name of Insured _____ Insured's Date of Birth _____

Insured's Social Security Number or Insurance I.D. Number _____

Insurance Company_____ Employer_____

Insurance Co.'s Phone number_____ Insurance Group #_____

Insurance Co.'s Address _____ City _____ State _____ Zip _____

****Please print name and sign below to indicate that you have read and fully understood said policy****

PRINT NAME _____ **SIGNATURE** _____

3592 Monroe Avenue, Pittsford, New York 14534 (585) 248-5250