FINANCIAL POLICY

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide you with the best possible care. In order to avoid any misunderstanding regarding financial/insurance arrangements, please carefully read and complete the following.

PATIENTS WITHOUT INSURANCE COVERAGE

Patients without insurance coverage are responsible for payment in full when services are rendered. Please indicate how you will settle your account today. _____ ***check*** _____ ***cash*** _____ ***credit card*** _____ ***Care Credit***

PATIENTS WITH INSURANCE COVERAGE

As a courtesy to our patients we will make every effort to obtain appropriate benefits from your insurance carrier(s). In order for us to properly complete insurance claims forms you must provide us with full and current insurance information including appropriate HMO referrals, **prior** to any services rendered in this office - otherwise, you are responsible for payment at the time of service. Please complete the following and present appropriate insurance cards to our front office staff.

PRIMARY INSURANCE INFORMATION

Medical Insurance Co. _____ Policy #_____ Group #_____
Subscriber's Full Name _____ Date of Birth_____
Subscriber's ID# (or SSN)_____ Relationship of patient to subscriber_____
Dental Insurance Co. _____ Policy #_____ Group # _____
Subscriber's Full Name _____ Date of Birth_____
Subscriber's ID# (or SSN)_____ Relationship of patient to subscriber_____

SECONDARY INSURANCE INFORMATION

Medical Insurance Co. _____Policy #_____Group #_____
Subscriber's Full Name _____ Date of Birth_____
Subscriber's ID# (or SSN)_____Relationship of patient to subscriber_____
Dental Insurance Co. _____ _Policy #_____ Group # _____
Subscriber's Full Name _____Date of Birth_____
Subscriber's ID# (or SSN)_____Relationship of patient to subscriber_____

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered services, secondary insurance, "usual and customary" charges, etc. other than to supply factual information as necessary. Portions of the bill may not be paid by the insurance company and are to be paid by the patient. Many times there are co-pays and/or deductibles. **A deposit will be required at the time of treatment as a credit against these unpaid items.** Even if you have double coverage (this is possible if you and your spouse both have insurance), there may still be a portion of the charges that will be your responsibility.

ADDITIONAL TERMS

Appointments canceled with less than 24 hours of notice may be subject to a $50.00 cancellation charge. Checks returned by your bank are subject to a $35.00 returned check charge. Accounts must be paid in full within 60 days from the "**START OF BILLING**" date and are subject to finance charges at the rate of ½% per month (6% per annum) thereafter. **In the event an account is not paid in full within 60 days of billing and must be referred for collection you will be responsible for a 30% collection fee on the outstanding balance which will include a minimum placement fee of $36.00, interest (6% per annum), and associated court costs and attorney's fees. My signature below authorizes the release of any medical, dental or other information (compliant to HIPPA regulations) necessary to process my claim(s) and/or provide information relevant to my care with any other healthcare provider or healthcare entity. A copy of HIPPA regulations is available upon request. I hereby authorize and direct payment of the medical/dental benefits otherwise payable to me directly to the provider(s) of service or their authorized entity.**

I have read and understand the financial policy of the office of Daniel J. Daley, Jr., D.D.S., P.C. The sections that I have completed are true and accurate.

_____ _____
Signature of Patient or Responsible Party Today's Date

Office Use Only
_____