Cosmo Dental

FINANCIAL POLICY

PATIENT NAME: _____

BASIC FINANCIAL POLICY: Payment-In-Full is due at time of service. We accept cash, check, credit card (Visa, MasterCard, American Express & Discover) and Care Credit (Prior approval required). There is a $25 charge for returned checks.

CANCELLATION POLICY: This office requires at least 72 hours notice to cancel an appointment. Notice must be given verbally to an employee and voicemail messages are not valid. There is a $100 fee for missed appointments without the required notice. ☐ **INITIAL**

COLLECTION POLICY: Past-Due accounts are subject to an monthly 1½% Interest Charge (18% yearly). Over-Due accounts are subject to a $150 Collection Charge and are sent to a Collection Agency. Collection efforts may have a negative impact on your credit score and credit report. ☐ **INITIAL**

WORKERS COMPENSATION/PERSONAL INJURY CASES: This office does not submit claims to Worker's Compensation or casualty insurance companies (i.e. auto accident or personal injury) for payment of services. Please make arrangements to Pay-In-Full, prior to receiving services.

FOR PATIENTS WITH INSURANCE: As a service to our patients, we accept "assignment of benefits" and will bill your insurance carrier, on your behalf. Please provide a copy of your insurance card, a valid ID and your Social Security/Member Identification number. We will collect your estimated co-payment and deductible, submit your claim to your primary and secondary insurance company and send a refund/statement for any over/underpayment.

HMO PARTICIPANTS: Some HMO insurance plans require specialist referral forms from your primary physician and pre-authorization, prior to services. Please provide the proper insurance plan information and necessary forms, prior to your appointment. All HMO co-payments are due at the time of service.

INSURANCE PATIENTS: IF PAYMENT IS DENIED BY INSURANCE CARRIER FOR ANY REASON, patient agrees to accept financial responsibility for all unpaid portions. Any unpaid balance is your responsibility and must be paid-in-full upon receipt of statement. ☐ **INITIAL**

ASSIGNMENT OF BENEFITS: I hereby assign all dental and/or medical benefits, including private insurance and all other health plans, to which I am entitled, to Olga Antipova, D.D.S. Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid, as the original. I hereby authorize said assignee to release all information necessary to secure payment on my behalf.

RECORDS RELEASE: Release of any patient's records including digital copy of X-Ray, either to the patient or to another dental facility is subject to **DUBLICATION OF RECORDS FEE** which is $100 ☐ **INITIAL**

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS OF THE FINANCIAL POLICY AGREEMENT.

GUARANTOR/PATIENT SIGNATURE _____ **DATE** _____