Robert M. Daddio, D.D.S

Financial Policy Consent

Directions: Please read the following and initial on every line stating you understand our office policies.

_____ 1.I understand that payment is due the day treatment is rendered.

_____ 2.I understand that any unpaid balance will be sent to a collection agency after 90 days. Unpaid balances will include any and all broken appointment charges if they apply. A collection agency fee of fifteen dollars ($15.00) will be applied to patients account. Statements for any unpaid balances will be mailed to the patient at thirty (30), sixty (60) and ninety (90) day intervals.

_____ 3. I understand that my dental records are the possession of Robert M. Daddio DDS.
The patient has the legal right to request their dental records at any time as described in the Notice of Privacy Practices. Due to Health Insurance Portability and Accountability Act of 1996 the patient's written consent to duplicate records will be required. The dental records will be provided to the patient within a reasonable time frame based upon the extent of the request. A nominal administrative charge may be charged based upon the extent of the requested the records. The fee starts at twenty-five dollars ($25.00). This fee will be required for the time and effort of the staff member(s) to assemble the specific requested records and contact 3rd party vendors.

_____4.The dental treatment plan demonstrates an estimation of your dental insurance coverage. **We have no control over what can and cannot be covered on an individual dental insurance policy.** A dental insurance policy is an agreement between a patient and the company they have purchased the policy from. The patient has the full responsibility of payment for any deductible, downgrade, non-covered procedures or co-insurance dictated by the insurance carrier. The patient has the ultimate responsibility to understand the dental insurance policy they have purchased and accepts responsibility for the full amount of charges incurred for their treatment.

_____ 5.For patients with dental insurance, we will directly bill the dental insurance carrier for reimbursement for your personalized dental treatment as a courtesy. The patient is also fully responsible for any amount not covered by the insurance carrier. **If the patient's insurance carrier does not pay for the filed claim within sixty (60) days the balance then becomes the patient's responsibility.**

_____6. Not all insurance plans cover certain services to restore your dental health**. In the event the plan you as the patient have purchased determines a service to be "not covered," you will be responsible for the complete charge.** These non-covered services will be discussed with the patient before they are rendered if the insurance carrier properly notifies us of such an event.

_____7. Robert Daddio DDS & Associates, charges a thirty-five dollar ($35.00) fee for each returned personal check(s). Once the personal check is returned, no further personal checks will be accepted. All future payments must be made with a credit card or cash.

_____8. For larger, more extensive dental appointment of fifteen hundred dollars ($1500.00) or more and over 1.5 hours of the doctor's time, a twenty five percent (25%) deposit is required to reserve your personalized dental treatment appointment. This deposit will be applied to the cost of the extensive personalized dental appointment. If the patient's insurance carrier does not pay for the filed claim within 60 days the balance then becomes the patient's responsibility.

By signing the consent for treatment and practice policies, you, the patient, verify that you have asked our doctor and/or staff all questions regarding additional information needed to fully understand the previous statements. You also consent for this practice to treat your oral health care needs and have the legal right to do so for yourself or for the patient if they are less than 18 years of age, an emancipated minor or incapable of making decisions regarding their health care (caregiver).

Patient's Name: (Please print)_____ Today's Date:_____

Patient's Signature:_____