AMERICAN COLLEGE OF PROSTHODONTISTS

NEW HAVEN PROSTHODONTICS, P.C.
FRANK P. MARATTA, DMD, FACP

FINANCIAL POLICY

PATIENTS WITH DENTAL INSURANCE:
Our office understands the value of insurance benefits, and we are happy to assist you in filing the necessary forms. This is done as a courtesy to our patients, and there is no guarantee of coverage. The insurance carriers base the amount of benefits on a set fee schedule they have developed for each procedure, which may differ from our office fees. Due to constantly changing insurance contracts, benefits, and deductibles, we are only able to estimate your insurance coverage. Your insurance policy is an agreement between you and your insurance carrier; therefore, all patients are directly responsible for all charges. If for any reason your insurance carrier has not paid within 60 days from the date of treatment, you are responsible for the entire balance at that time. Payments of estimated patient portions are expected as services are rendered. Insurance companies may deny your claim, at which time you are responsible for the whole balance.

PATIENTS WITHOUT DENTAL INSURANCE:
Payment in full is expected at the time services are completed. A deposit is expected to begin all treatment. We accept cash, check, VISA, MasterCard, and Discover. If payment is made in full with cash or check, a 5% discount is provided.

CARECREDIT: We offer financial assistance through CareCredit. If approved, CareCredit allows you to finance your treatment over a period of 12 months with no interest. An administrative fee may apply.

All returned checks will assess a $25 returned check fee.
If full payment is not received 90 days from the date of treatment completion, the account will be turned over for further collection action. In the event of a default, legal interest on the indebtedness, collection costs (which could be as high as an additional 50%) and related attorney's fee could be added.

By signing below I verify that I completely understand, agree, and accept the policies as outlined above. I further acknowledge that I am ultimately responsible for all dental services rendered to me and my dependants (if applicable).

Patient Name: _____ Date: _____

Signature: _____

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