PERIODONTAL ASSOCIATES, LLC
61 FOURTH STREET, STAMFORD, CONNECTICUT 06905
(203)325-3141

FINANCIAL POLICY

1. Unless payment arrangements have been approved in advance by our Office Manager, payment for services is due at the time services are rendered. Accepted form of payment includes Cash, Check, MasterCard, Visa and CareCredit.
2. **Returned checks** are subject to a $35 service fee.
3. **Broken appointment:** A fee of $50 per half hour scheduled appointment will be applied to any broken appointments and cancellations without 24 hours advance notice. If you have an appointment for Implant Placement, we require 72 hours cancellation notice.
4. **Overdue Balance:** Account balances are due in full within 30 days from the initial statement date. If you are unable to make payment timely, it is your responsibility to contact our Office Manager immediately for assistance in managing your past due account to avoid possible collection fees and procedures. We also reserve the right to cancel any scheduled future appointments for accounts that are 60 days past due.

About your dental insurance

1. Your insurance coverage is a contract drawn up by your employer and the insurance company, such that each group plan varies widely. Unlike medical insurance where there is a fixed copay per office visit, your out of pocket expenses with dental insurance will be based on your plan's Reimbursement Level, Co-payment Level, Maximum Benefit Allowance, Deductibles, and other limitations specified. While we make every effort to help you obtain the maximum allowable benefits, and to give you an accurate estimate on your portion of the treatment fees, please note that we cannot guarantee benefit payout by your insurance.
2. If you are filling your own insurance claim, we will gladly provide you with a claim form and detailed statement, but payment in full is due at the time of visit.
3. If you have primary and secondary dental insurances, we will submit your claim to both carriers.
4. We do not submit to medical insurance.

Your periodontal health is important to us, and we value our relationship as your dental care provider. This financial policy is aimed to avoid any misunderstanding and disagreement on your account charges. If you have any question regarding our policy, please do not hesitate to speak with us. We believe that a successful relationship is based on open communication, and we are here to help.

I understand and agree to the above financial policy of Periodontal Associates, LLC

Signature: ______________________________ Date: ________________