Tammy Perison, D.D.S

425 Main Street

West Seneca, NY 14224

(716) 674-5256

Financial Agreement & Authorization for Treatment

 We are committed to providing you with the highest quality dental care using the best materials and technology available on the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This policy is intended to facilitate excellent service to you while minimizing our administrative cost.

 I authorize treatment of the person named below. I agree to pay all fees for me and members of my family shown by statements, promptly upon receiving, unless other financial arrangements are agreed upon in writing. Fees shown by statements are agreed to be correct and reasonable unless protested within thirty days of the billing date. In the event any action should become necessary to collect an unpaid balance due for services rendered to me or my family, I/we agree to pay reasonable attorney’s fees, collection fees, or other such costs.

 All charges you incur are your responsibility regardless of insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. If payment from your insurance company is not received within 31 days from date of service, you will be expected to pay the balance in full. Any balance over 30 days will be subject to a billing fee of $20.00 per month.

 As a courtesy to you we will help you process insurance claims. You may direct your insurance payment to pay your benefits directly to our office by signing the authorization below for the Assignment of Benefits Agreement. In order for our office to file your insurance claims, you must provide proof of insurance at each visit and sign the HIPPA form.

 Copays are due at the time of service. For your convenience, the office accepts cash, personal checks, MasterCard, Visa, Discover and Wells Fargo. There is a $35.00 fee for returned checks.

 When an appointment is scheduled in our office, we have reserved that time just for you. We require a 2-business day notice to reschedule your appointment. If we do not receive a 2-business day notice your account will be charged a minimum of $50.00, depending on the time that was reserved for you.

 Accounts over 90 days may go to an outside collection agency. You agree to pay up to 35% collection cost. You agree to pay all attorney’s fees, collection fees, or other such cost.

 There will be a $25 fee per sheet for duplicating x-rays, and $.75 per sheet for duplicating charts.

**I HAVE READ AND UNDERSTAND THE PRECEDING FINANCIAL POLICY**

Print Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Patient/Guardian if minor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_