Dental Arts of Rockland

Dr. Steven Blechman

Office Policies and Financial Agreement

We view our patient relationships with a deep sense of responsibility. A major part of that responsibility is to help our patients understand and plan for their oral health along with providing each patient with the highest quality of dental care. The following is a statement of Dental Arts of Rockland's Office Policies and Financial Agreement. We ask that you please read, agree to and sign the agreement before any treatment is rendered.

Regarding Insurance

For decades dental insurance has been an integral part of oral health planning; however, in the past few years it has become more difficult for the dental practice to deal with insurance companies. We are a third party to the contract and the insurance companies are not obligated to share your confidential policy information with us or required to send payment to us.

There are constant changes being made by your employer and insurance carriers to your coverage, deductibles and annual maximum. These changes are not being shared with us. Therefore, it is impossible for us to know exactly what your policy covers.

In order for us to maintain our high level of service to you the patient, we provide the courtesy of submitting the claim on your behalf and supporting you with maximizing your benefits. However, we are unable to carry your insurance balance for longer than 60 days. Policy coverage, changes and follow-up on unpaid claims is your responsibility. Please be prepared to show your insurance card at the time of the visit. _____ (Initial)

Payment Options

Your options include Cash, Check, MasterCard, Visa, Discover and American Express. We are pleased to offer you a choice of No Interest or Extended Payment Plans to qualified applicants through CareCredit, our financial partner. If you would like to make extended payments for services provided at our office, please ask Colleen for assistance in filling out an application form. _____ (Initial)

Cancellation Policy

If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of **two** business days notice. All changes in your scheduled appointment **must** be handled during our regular business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. _____ (Initial)

Office Hours:

Monday	10:00 AM – 7:00 PM
Tuesday	9:00 AM – 5:00 PM
Wednesday	8:30 AM – 5:00 PM
Thursday	9:00 AM – 6:00 PM
Friday	10:00 AM – 2:30 PM
Alternate Saturdays	8:00 AM – 1:00 PM

I have read, understand and agree to the above Office Policies and Financial Agreement.-

_____ _____

PATIENT SIGNATURE **DATE**

(PARENT/GUARANTOR signature if Patient is a MINOR

_____

CHILD'S NAME