Cattafesta Family & Cosmetic Dentistry

Financial Policies

Your signature at the bottom of this page indicates that you understand and agree to our financial policies.

Full payment is due at the time services are rendered.

For Patients with Dental Insurance:
We do accept assignments of your insurance benefits; however, we do require that your co-payment and deductible be paid in full at the time of your appointment. The balance is your responsibility whether your insurance pays for your treatment or not. In the event that you insurance does not pay as much as we anticipate, you are responsible for the remaining bill. It is imperative that you inform us of any changes in your insurance coverage.

_____(Initial)

Prior to treatment:
Please be aware that not all services may be covered by insurance. The office cannot know all of the coverage limitations and rules of plan. To avoid any miscommunication or billing disputes, please contact your insurance company before services are provided. It is important that you read and understand the provisions of your insurance. Although we will be happy to assist you in any way we can, your insurance policy is a contract between you, your employer, and the insurance company, and you are responsible for knowing your benefits. Please be aware that some, or perhaps all, of the services provided may not be covered (or may be considered at an alternate benefit). If there is a problem with your insurance company, we will try to help. **Any claims unpaid within 60 days of the date of service, becomes the patient's responsibility.**

_____(Initial)

No Show/Cancellation Policies:
If you do not cancel your appointment within 48 hours or No-Show for an appointment, you will be charged a fee of $50.00 per half hour of scheduled time, which will be due prior to your next scheduled appointment. All cancellation and No-Show appointments are documented in the chart and become part of your record.

Payment may be made Via Cash, Check, Visa, MasterCard, Discover, or American Express.
There is a $30 + $5 bank fee for all returned checks.

Signature: _____

Date: _____

Patient Name(s): _____