WESTBURY DENTAL
Implant & General Dentistry

WESTBURY DENTAL
1600 Stewart Ave, Suite 102
Westbury, NY 11590
(516) 683-0888
westburydentalny@gmail.com

FINANCIAL AND INSURANCE

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due at the time of service. I understand any treatment fee will be honored up to 90 days from the date of examination. I understand, in order to collect any debt, my credit history may be checked through the use of my social security number and any other information given.

I understand that there is a $25 monthly late fee if I do not pay my balance within 30 days of a statement due date. There is a $35 processing charge for non-sufficient funds or returned checks. I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, costs, expenses, and court costs incurred in the collection.

I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment.

As a courtesy to me, I understand this office will file any dental insurance for me. I hereby authorize the release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

I understand this office will always do the best to help me maximize my dental benefits; however, the ultimate responsibility for payment is mine; and I am obligated and agree to pay this office in accordance with its credit terms and policy.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

☐ **I do not agree to the content above and/or do not want to disclose my SSN.** I realize this is my choice, and I can still get treatment here. I do understand this comes with the following changes: 1) all treatment will need to be paid in full at time of service, 2) insurance will reimburse me and not my dentist, 3) I must pay with a credit card or cash, 4) no payment arrangements will be possible, and 5) often insurance cannot be verified and estimates will be less accurate.

_____

Patient/Parent/Guardian Signature (Responsible Party) Date

_____

Relationship to Patient