Financial Policy

Thank you for choosing The Tzagournis Dental Group as your dental health care provider. We are committed to providing you with the highest quality dental care. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **All patients must complete our "Patient Registration Form" before seeing the dental professional.**
- **Full payment is due at the time of service.**
- **We accept Cash, Personal Checks and most major credit cards. We Do Not accept American Express** **All credit card payments will have a* **$5.00** *usage fee.* We also accept Care Credit.
- **Tzagournis Dental Group provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service.**

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges.

Adult Patients:
Adult patients are responsible for full payment at time of service.

Minors accompanied by an adult:
The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

Unaccompanied minors: The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized by a parent or guardian.

Missed Appointments:
Unless cancelled at least 24 hours in advance, a cancellation fee of $50.00 will be assessed for broken or missed appointments.
All appointments must be held with **a valid credit card at the time of scheduling once you have a broken or missed appointment without the 24 hour notification on file**. A credit card hold transaction may be made on your credit card to reserve the appointment time. Your credit card information will be stored with full encryption. Please help us serve you better by keeping scheduled appointments.

Insurance: Tzagournis Dental Group provides insurance company billing as a courtesy to our patients. **The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company.** In addition, certain insurance companies have annual

limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed that particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely on any information provided by the Tzagournis Dental Group staff regarding his/her remaining benefit in any such benefit period.
As a patient you are always responsible for the knowledge of your insurance coverage, as well as, the accountability for any charges that are not covered by your insurance.

Delinquent Payments:
It is our policy to charge finance fees at **4%** for outstanding patient balances after the balance has been outstanding for 30 days, and all insurance claims have been received and processed. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $35.00.

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will process insurance claims. Please understand that we will provide an **insurance estimate** to you, however, it is not a guarantee that your insurance will pay exactly as estimated. **Your insurance company and your plan benefits will determine the amount paid.** If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. Please keep your insurance information current by notifying us of any changes in employment and insurance coverage.
- We ask that you pay the deductible and co-payment, which is the **estimated amount**, not covered by your insurance company, by cash, check, or credit card (*please note, credit card payments have a five dollar ($5.00) usage fee*).
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your dental care or our financial policy.

Patient Name: _____________________________ Date:___/___/____

Patient Signature:_____________________________