

PLEASE READ AND SIGN THIS FORM BEFORE RETURNING IT TO THE FRONT DESK

## **DENTAL SOLUTIONS- DR. ERIC C. WEISS, DMD**

### **Payment Policy**

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our policy which we require you to read and sign before any treatment.

All patients must complete their information before seeing the doctor. We are now participating with Cigna, Delta Dental, Dentemax and United Concordia. If we do not participate with your insurance plan, **Full payment is due at the time of service.** We accept cash, checks, Visa and MasterCard. We will submit a claim to your insurance carrier for you. Your carrier will reimburse you directly.

In the event your insurance coverage changes, it is your responsibility to make us aware of this change and provide us with the new card/information.

### **Usual and Customary Rates**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. **YOU ARE RESPONSIBLE FOR PAYMENT REGARDLESS OF ANY INSURANCE COMPANY'S ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES.**

### **Minor Patients**

The adult/parent/guardian accompanying a minor is responsible for full payment at the time of service and for future treatment. This is our policy regardless of divorce/separation and court-mandated designation of responsible party. We are not a party to any such order of the court. Our relationship is established with you.

### **Miscellaneous**

There will be a \$40.00 charge for all failed appointments if we do not receive 24 hour notice of your appointment being canceled.

There will be a \$35.00 fee for all checks returned unpaid by the bank.

**I HAVE READ, UNDERSTAND AND AGREE TO THE POLICY.**

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Patient Signature

Date