**Joanne M. Butler DDS**
**166 Park Avenue**
**Manhasset NY 11030**

## PRACTICE FINANCIAL POLICY

**We are dedicated to providing you with the best possible dental care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy.**

1. **Unless other arrangements have been agreed upon in advance by either yourself or your health coverage carrier, full payment is due at date of service. For your convenience, we accept cash, checks, Visa, MasterCard, American Express and debit cards.**

2. **We have made prior arrangements with many insurers and other health plans.** *YOU ARE RESPONSIBLE FOR INFORMING US OF ANY CHANGES IN YOUR INSURANCE.*

3. **We will bill those plans with whom we have made an arrangement, or participate with and will collect any required co-payment and deductible on day of service upon arrival. If we do not receive payment from your health plan provider, for any reason, within 60 days, you are responsible for that portion of the charges.** *In the event your health plan determines a service "not covered" you will be responsible for the office's complete charge.* **In either event, we will bill you and the payment is due upon receipt of the statement.**

4. **If you have insurance coverage with a plan with which we do not participate or have a prior agreement, we will prepare a claim for you on an unassigned basis. In this case, your insurer will send the payment directly to you. The charges for your care and treatment are due at the time of service.**

5. **Copies of charts and/or X- rays are available upon written request and payment of a fee. We reserve the right to charge for school forms, employer letters, and excuse letters.**

6. **In order to provide the best possible service and availability to all our patients, YOU WILL BE CHARGED OUR OFFICE VISIT FEE FOR ANY APPOINTMENTS BROKEN OR CANCELLED WITHOUT FORTY-EIGHT (48) HOURS, TWO BUSINESS DAYS NOTICE. (_____) <** *INITIAL*

7. **THERE IS AN ADDITIONAL BILLING FEE FOR PAYMENTS NOT MADE ON THE DAY OF SERVICE. For accounts that have not been paid after (30) thirty days, there is a BILLING FEE and 1 ½% interest finance charge per month ($2 minimum charge) (_____)<INITIAL**

**"I have read and understood the financial policy of the practice, and I agree to be bound to its terms."**

_____ _____

*Signature of patient or responsible party* *today's date*

_____

*Print name of patient*

*I have received and understood the copy of this office's NOTICE OF PRIVACY ACTS*

_____

*Signature of patient or responsible party*