



The
Geller Dental Group P.C.

COMPREHENSIVE CARE FOR THE ENTIRE FAMILY

FINANCIAL AND APPOINTMENT POLICY

2140 Bellmore Ave., Bellmore, NY 11710

Phone 516-785-4744

Fax: 516-785-4790

www.theGellerDentalGroup.com

FINANCIAL ARRANGEMENTS

Due to the highly specialized treatment that dentists provide, most treatment plans are usually complex. As a result of the amount of time that we invest in your treatment, along with material and overhead costs, payment is expected in full at the time of service unless other arrangements have been made in writing. For your convenience, we accept all major credit cards.

If you have dental insurance, we will contact your insurance company for you and determine as close as is possible what your portion is to pay on the date of service. This information is an estimate only and we cannot guarantee its accuracy. After your insurance company pays their portion, we will inform you of what balance, if any, is outstanding for you to pay. This amount will be due upon notification. Please note that your insurance policy is a contract between you and your insurance carrier. It is your responsibility to understand your plan benefits. If for any reason your insurance carrier does not pay within forty-five days, as allowed by law, the balance will become your responsibility. Any past due balance is subject to a monthly finance charge. In the unfortunate circumstance that your account becomes more than 90 days overdue, we will send your account to our collection agency, your account will also be charged an additional collection fee of \$50.00

Initial Here

APPOINTMENT POLICY

The complex nature of your dental treatment requires a series of appointments with explicit amounts of time periods between them to allow us to complete your treatment to the high standards that we constantly strive to achieve. Once your appointment schedule is determined it is then coordinated with the dental laboratory in order to achieve a smooth progression of your treatment. It is imperative that your appointments be maintained in order, otherwise your treatment may be delayed by several months. If you constantly change the dates of your appointments, this in turn affects the laboratory schedule of your treatment, and in this event we may not be able to complete your treatment in a timely manner.

Should you need to change a scheduled appointment, we would appreciate the courtesy of being informed at least 48 hours in advance. If your appointment is for 2 hours or more, we require at least 4 working days notice. Due to the large amount of time involved in prosthetic treatment, other patients who may wish to take your appointment time require several days notice in order to accommodate their schedules. We reserve the right to charge your account a missed appointment fee if appointments are not cancelled with sufficient notice.

Initial Here

AGREEMENT

I understand the financial arrangements and agree with this payment schedule as a method of payment for my treatment. I understand that I am responsible for my total dental cost regardless of any insurance coverage.

Initial Here

Signature _____ Date _____