COSMO DENTAL
FINANCIAL POLICY

PATIENT NAME:____

BASIC FINANCIAL POLICY: Payment-In-Full is due at time of service. We accept cash, credit/debit card (Visa, MasterCard, American Express & Discover) and Care Credit (Prior approval required).

CANCELLATION POLICY: This office requires at least 72 hours notice to cancel an appointment. Notice must be given verbally to an employee and voicemail messages are not valid. There is a $100 fee for missed appointments without the required notice. [ ] **INITIAL your card may be charged for missed appointments.**

Please provide your credit card information in order to book your next appointment

(it will not be charged, it is only to book an appointment, unless you have a missed visit)

Name on the card ____

Credit card number____

Expiration date ____

3 digit verification code on the back________________________________

COLLECTION POLICY: Past-Due (30 days) accounts are subject to a monthly 4.2% Interest Charge (50.4% yearly). Over-Due (31+ days) accounts are subject to a $300 Collection Charge and are sent to a Collection Agency. Collection efforts may have a negative impact on your credit score and credit report. **INITIAL** [ ]

FOR PATIENTS WITH INSURANCE: As a service to our patients, we accept "assignment of benefits" and will bill your insurance carrier, on your behalf. Please provide a copy of your insurance card, a valid ID and your Social Security/Member Identification number. We will collect your estimated co-payment and deductible, submit your claim to your primary and secondary insurance company and send a refund/statement for any over/underpayment.

INSURANCE PATIENTS: IF PAYMENT IS DENIED BY INSURANCE CARRIER FOR ANY REASON, patient agrees to accept financial responsibility for all unpaid portions. Any unpaid balance is your responsibility and must be paid-in-full upon receipt of statement. [ ] **INITIAL**

ASSIGNMENT OF BENEFITS: I hereby assign all dental and/or medical benefits, including private insurance and all other health plans, to which I am entitled, to Olga Antipova, D.D.S. Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid, as the original. I hereby authorize said assignee to release all information necessary to secure payment on my behalf.

RECORDS RELEASE: Release of any patient's records including digital copy of X-Ray, either to the patient or to another dental facility is subject to **DUBLICATION OF RECORDS FEE** which is $100 [ ] **INITIAL**
(Applies only if there is an outstanding balance or insurance has not covered the cost)

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS OF THE FINANCIAL POLICY AGREEMENT.

GUARANTOR/PATIENT SIGNATURE **DATE**