425 ESSEX STREET
MILLBURN, NJ 07041

PHONE: 973 535 4300
FAX: 973 535 4308

Arthur Greyf DDS, FICOI
Implant, Cosmetic & Laser Dentistry

FINANCIAL POLICY

Thank you for choosing DNA Dental PC as your dental care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment

TREATMENT:

Please understand that under no circumstance your treatment should be dictated by your plan allowances. Your treatment will be discussed with you upon examination. All your questions regarding your treatment will be answered by our dentists and staff. **Please understand that our dentist do not base your treatment on the insurance company limitations. The treatment plan will be presented to you based on your dental needs.** You will receive a financial estimate based on the information provided to us by you and your insurance company before your next appointment. **Please understand that we are not liable for any and all incorrect information we receive from you or your insurance company.**

FINANCING:

We arrange financing for qualified patients through a third party financial service on the amounts over $1000.00.

INSURANCE

We participate with multiple insurance companies. You and covered members are financially responsible for all limitations, deductibles, waiting periods, alternative treatment limitations and any other limitations your plan imposes on you the insured. It is your responsibility to know and understand your plan.
Please understand that your coverage is selected by your employer. Therefore your employer is the only reliable source of your exact coverage and limitations. Your account balance is your responsibility **whether** your insurance company pays or not. In the event we do accept assignment of benefits (wait for your insurance portion of the payment) we require the portion not covered by your insurance to be paid at time of service. Please understand that we will make every reasonable effort to collect from your insurance company according to your contract with the insurance carrier. **If your insurance company has not paid your account in full within 90 days, the balance will automatically be transferred to you. All co-pays and deductibles are due on the day of treatment. You will incur 15% annual service charge on the entire balance.**

Note: Please understand that most insurance do not cover you for all services. Some services are negotiated at a lower rate to be paid by insured; some are not covered at all. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered necessary under your insurance policy. Should your account be transferred for collection, you will be charged a collection fee.

YOU ARE RESPONSIBLE FOR KNOWING WHAT YOUR PLAN COVERS AND MAXIMUM UTILIZED FOR THE YEAR.

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PATIENT RESPONSIBLITY:

Adult patients are responsible for full payment at time of service unless prior arrangements have been made. Your financial estimate will reflect the amounts due for each service at the time of treatment. Please understand that in the event your insurance company does not cover the portion expected from them within 90 days the balance will be transferred to your account and will become due at that time. The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment unless prior arrangements have been made.

MISSED APPOINTMENT:

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of **50 dollars** per hour and **100 dollars** for **Saturday missed appointments. YOU ARE RESPONSIBLE FOR REMEMBERING YOUR APPOINTMENT. DNA Dental call as a courtesy and will not be held responsible for missed appointments.**

I have read the Financial Policy. I understand and agree to this Financial Policy:

Signature of Patient or Responsible Party: ______________________________

Date: ______________________