BACK BAY DENTAL

DR. NICHOLAS CIANCARELLI

FINANCIAL POLICY

Thank you for choosing Back Bay Dental. We are committed to providing the best care for our patients and making your experience a positive one.

Payment Policy: We ask that you read this financial policy and sign the bottom of the page prior to any treatment or consultation. Full payment, or co-payment for those with insurance, is due at the time of service. We accept Cash, Checks or Credit Card payments. There is a $30.00 fee charge for checks returned due to insufficient funds.

Insurance Policy: We participate in network with Delta Dental, but we will submit to any insurance company as a courtesy, if you provide us with an updated insurance card prior to service. Please understand that your policy is a contract between you and your insurance company; we are not a party to that contract. You are responsible for any amount not covered or paid by your insurance company, regardless of policy benefits. Insurance co-payments are due at the time of service. If you do not have insurance or are ineligible for coverage, you are responsible for the entire treatment cost paid on the date of service. At your request, a pre-authorization can be submitted to your insurance company in advance of any major work as an accurate estimate of their payment. Some insurance companies are notorious for delaying or denying payment regardless of necessity. If you are insured with one of these companies, a credit card will need to be placed on file.

Missed and Cancelled Appointments: We do require at least 24 hours' notice of cancellation prior to your appointment. Failure to provide accurate cancellation notice for a hygiene appointment or failing to show for a hygiene appointment will result in a $40.00 fee. Failure to provide an accurate cancellation notice for an appointment with the dentist or missing an appointment with the dentist will result in a $100.00 fee. These fees are required to be paid on the next visit or within 90 days, whichever comes first.

Minor Patients: Parent or guardian is responsible for all charges for minor children.

Please let us know if you have any questions regarding our financial policy. I agree to pay my bill within 90 days of treatment regardless of the status and amount of the insurance company payment. I have read and agree with this Financial Policy.

X_____ X_____ x_____

Signature/Person Financially Responsible | Please Print Name | Date

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