KAISER & ROSEN
DENTAL ASSOCIATES

FINANCIAL POLICY

Our office is committed to providing you with quality dental care at a reasonable fee. We participate with many insurance programs and accept assignment of benefits. This means that you will only be required to pay your deductible and co-payments at the time of service. State law requires us to collect all out-of-pocket expenses related to patient care including deductibles, co-payments, co-insurance and non-covered procedures. You may also find in your insurance manual that you are contractually obligated to pay these expenses, which are designated as being the responsibility of the patient.

All payments are due at the time of service. Statements for other outstanding balances are mailed to patients monthly. Please make sure we have your current address. For your convenience we accept payments by credit card in addition to cash and checks. This allows our patients the opportunity to satisfy their account promptly. Accounts that are delinquent will be charged interest and penalties. Any account that becomes seriously delinquent will be sent to collections.

Our office does require that any patient that is unable to keep a scheduled appointment must provide us with 24 hours notice. Patients unable to give notice or failing to show up for an appointment will be assessed a minimum charge of $80.00. This applies to all patients regardless of insurance coverage.

All balances not paid by your insurance carrier, within 60 days of treatment, must be paid by the patient at that time. The patient will be responsible for any other amounts incidental to payment for service, including returned check charges, interest on past due balances, collection fees including court costs.

I UNDERSTAND and agree to these terms as they pertain to payment for services I receive from Kaiser & Rosen Dental Associates, P.C. I authorize Kaiser & Rosen Dental Associates, P.C. to release any information acquired in the course of any treatment necessary to process insurance claims. I also authorize payment directly to the provider and/or dental benefits, if any, otherwise payable to me for services as described, realizing I am responsible to pay for any deductible, co-payment, coinsurance and non-covered services and goods.

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Print Patients Name **DATE**

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Patient's Signature

2137 Welsh Road; Suite 3-C ● Philadelphia PA 19115
215.464.5600