



Dr. Mitesh Faldu B. Pharm., RPh, DMD
Implants and Periodontics
555 Iron Bridge Road Freehold NJ 07728
Tel: 732.409.0090
Fax: 732.409.9988

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being pleasant and successful. Please understand that payment of your bill is considered part of your treatment. The following is our financial policy, which we request that you read, agree to, and sign prior to any treatment.

CASES WHERE INSURANCE IS INVOLVED

We will try to verify your insurance coverage. When this is done, we will approximate all deductible, co-pay, and any portion of the bill you will be responsible for. We do this as a courtesy to our patients. However, **it is your responsibility to understand how your insurance plan works.** We will require that you pay your portion of the bill at the time of treatment. We will be happy to submit any and all insurance forms necessary. If in the event after we have been paid by your insurance, there is still a balance due, we will require that you pay that within 15 days of receiving a statement from our office. If in the rare event you have overpaid, we will give you the same courtesy we expect. We will reimburse you within 15 days after your request. Because we can sometime only approximate from the information we are give from your insurance company, these sometimes occur.

Please remember that, your dental insurance is a contract between you (or your employer) and the insurance company. We are not a part to that agreement.

As your care provider, our relationship is with you, not your insurance company. **We will recommend the best possible treatment for you, regardless of coverage limitations.** Keep in mind that insurance companies stay in business by minimizing payment of benefits.

CASES WHERE INSURANCE WILL NOT BE INVOLVED:

If treatment will be under \$500.00, we will expect payment in full at the initiation of treatment. If your treatment fees is more than \$500.00, and your are not able to pay in full at time of treatment, we will require 50% at initiation of treatment, 50% upon completion of treatment.

FORMS OF PAYMENT WE OFFER:

Cash Checks Visa Master Card
 Discover American Express CitiHealth Card

In the event you do not meet your commitment, a \$5.00 rebilling fee will be added on to each month a statement must be sent (This may be in addition to finance charge). 1.5% Monthly finance fee may be applied to balance 30 or more days past due. There is a fee of \$30.00 for returned checks. In the event the use of a collection agency is required, an additional fee of \$50.00 will be applied for collections management.

There is a \$75.00 charge for a missed appointment or if 24 hours notice is not given. This fee is not covered by any of the insurances.

Thank you and if you have any questions please feel free to ask the receptionist, she will be happy to help you. I have read, understand, and agree to the provisions of this financial policy.

Fees are in effect for 6 months.

Signed _____ Date _____

Patient/Parent or Guardian if patient under 18 years of age.