FINANCIAL AGREEMENT FOR THE OFFICE OF PROSTHODONTICS OF NEW YORK

18 EAST 48TH STREET, SUITE 1501
NEW YORK, NY 10017
TELEPHONE: 212-758-9690 FAX: 347-230-5152

- This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you.

- All charges incurred are your responsibility regardless of your insurance coverage. As your dental care provider, our relationship and responsibility is with you, our patient. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract.

- As a courtesy we will furnish you with the necessary information, to be submitted with your insurance claims. To have benefits paid directly to you, please sign the authorization on your insurance claim form.

- Payment for dental treatment is due at the time services are provided, unless prior arrangements have been made. Payment methods include cash, personal check, MasterCard, Visa, Discover and American Express. Should you need an extended payment period, Healthcare Financing is available. For patients undergoing extensive Prosthetic treatment, our Patient Care Coordinator will arrange a customized payment schedule.

- Additionally, it is our policy to charge you for appointments that you do not keep and for appointments that you do not cancel with 24-hour notice. I'm sure you'll understand the necessity for this. This allows us the opportunity to schedule another patient. Our goal is to honor both your appointment time as well as the doctors.

- Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

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Print Name of Patient or Responsible Party

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Signature Date