

Harry L. Weisnefeld, D.D.S.
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Staten Island, NY 10314
(718) 494 – 0100

Financial Arrangement Agreement

We are committed to providing you with the best possible care. Please provide us with your dental insurance information (if applicable). We would like to help you receive your maximum allowable benefits from your insurance company and in order to do this, we need your understanding of our payment policy.

Payment is due at time of treatment. We accept cash, check, and most credit cards.

If your insurance company requires a signed form, please bring one with you each visit. We cannot submit for payment without a form (if required by the insurance company). Some insurance companies have time limitations on claim submittal so please try to bring a completed form with you each visit.

We will gladly discuss your proposed treatment. We will answer any questions relating to your insurance coverage to the best of our knowledge. If certain services aren't covered by your insurer, we will do our best in notifying you before treatment is started. Please understand that we send Pre-treatment estimates whenever possible and many insurance companies approvals are subject to change without notification to us.

Please realize:

1. Your insurance coverage is a contract between you and your employer and/or the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowed by each individual insurance carrier. Some insurances pay by percentage and you will be responsible for co payments and/or deductibles are applicable. Some insurances may be "reduced fee schedules" which patients are required to pay at time of service. Please be aware how your insurance works.
3. Not all services are covered, therefore payments for these services are the patient's total responsibility and payment must be arranged.

We realize temporary financial problems may effect timely payments on your account. If such problems do arise, we encourage you to contact us promptly so we can work out arrangements.

If you have any questions or concerns, please don't hesitate to ask. We are here to help you.

I do understand that if I do not have insurance I am responsible for payment at time of service and arrangements may be made.

An additional \$20 will be charged for a returned check. Broken appointments are subject to a fee. We require 24 hour notice for cancellations.

If your account becomes delinquent, you will be responsible for all collection fees and attorney charges. If your account is sent to a collection agency, 30% to 50% will be added to the entire collection amount.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While filing insurance claims is a courtesy that we extend to all our patients, all co-payments and uncovered charges will be your responsibility.

**I understand and agree that regardless of my insurance status, I will be ultimately responsible for the balance of my account and services rendered. I have read all the information above and I full understand my responsibilities.

Print Patient's Name

Signature (guardian must sign for minors)

Date

Social Security #