Dr. John Feeley

OUR FINANCIAL POLICY

****Please read carefully and initial each paragraph:****

______ **IF YOU HAVE NO INSURACE COVERAGE:**
PAYMENT IS EXPECTED AT THE TIME OF SERVICE

______ **IF YOU HAVE PRIVATE INSURACE:** (e.g. Delta Dental, BC/BS, MetLife, Cigna, Aetna, etc.)
Your insurance policy is a contract between you, or your employer, and the insurance company. As a courtesy to you, we will file your claim(s) for reimbursement, and ESTIMATE our co-payment. CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. If your insurance company pays less than expected, you will be responsible for the difference. Patients who fail to provide sufficient insurance information will be required to pay in full upon receipt of services. Failure to pay the co-payment may result in rescheduling your appointment.

______ **IF YOU HAVE DOUBLE COVERAGE:**
Double coverage does not guarantee that you will not owe any money toward dental care. CO-PAYMENTS AND DEDUCTIBLES, IF ANY, ARE DUE AT THE TIME OF SERVICE.

INSURANCE INFORMATION

Dental Insurance Name:____

Insurance Phone Number:______________________ Group #:______________ Plan #:________________

Insured's Name:_____________________________________ Date of Birth:_________________________

SS#:____________________ Employer:______________________ Relationship to Patient______________

______ **MISSED APPOINTMENTS:**
A fee of $25 per ½ hour will be charged for missed appointments. CANCELLATIONS MUST BE MADE AT LEAST 24 HOURS IN ADVANCE. Some dental plans specify a specific fee for missed appointments.

Thank You! We will be happy to help you with any questions you may have.

SERVICE CHARGE

If I do not pay the entire balance within 30 days of the monthly billing date, a service charge will be added to the

account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a

minimum charge of $3.00 for a balance under $200.00). In the case of default of payment, I promise to pay any

interest on balance due, a 35% collections fee, together with any additional collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Signature:______________________________________ Date:____
(Responsible Party)