

Our Financial Policy
Please Read, Sign and Return

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

This office will attempt to work within the limits of your insurance policy and help you to receive maximum benefits. However, it is important that you, the patient, understand the following:

- *It is the patient's responsibility to be familiar with the terms of his/her insurance policy.*
- *Treatment is billed to the insurance company and you are responsible for whatever they do not cover.*
- *PDO's & PPO's are fee schedules that, (if we are participating provider), we are under contractual agreement to abide by. These fee schedules provide for generous discounts from our usual fees. However, in most cases there will still be a balance for treatment after payment from insurance.*
- *If your insurance plan includes co-payments or deductibles, these amounts must be remitted during the period of time that treatment is taking place.*
- *If there is a remaining balance, or if a treatment is not covered, fees must be paid within 30 days of billing or finance charges will accrue at a rate of 8.5% and will be added to any amount past due, as well as a \$2.50 handling charge per additional statement sent after the first billing.*
- *If a payment arrangement is necessary, payments are due within the terms agreed upon. Otherwise, finance charges will accrue at a rate of 8.5%.*
- *You, the patient, are responsible for keeping track of the maximum allowances paid on your dental work.*

I understand my signature requests that payment be made by my insurance policy to the Office of Dr. Albert V. Biggiani for any services furnished to me by that dental office. I authorize the release of any of my dental information necessary to determine the benefits or the benefits payable to related services on my behalf. I also understand that I am responsible for any amount not covered by my insurance. It is my responsibility to pay reasonable attorney fees if my account is referred to an attorney for collection.

8.5% interest will be added to any amount past due

Thank you for understanding our financial policy. If you have any questions or concerns about our fees, our financial policy or your responsibility, please do not hesitate to ask.

Signature of Responsible Party _____ *date* _____