Zhukovsky Dental Clinic

1812 Quentin Rd. Ste M1

Brooklyn, NY 11229

Financial Policy

PATIENT DETAILS

First Name* **Middle Name** **Last Name ***

Date of Birth *

Gender ○ **Male** ○ **Female** ○ **Prefer not to say** **Marital Status**

FINANCIAL POLICY

Please read this Financial Policy carefully, then sign to acknowledge your understanding and agreement to the terms of the Financial Policy. Thank you for choosing us as your dental care provider. We are committed to providing you with dental care available.

Available Payment Options: **Cash, Check, Visa, Mastercard, American Express**

CareCredit: We also offer a payment plan option; please ask us for further information regarding this option.

Insurance: Coverage and Co-pays

*** For covered services, all co-pays and deductibles must be paid on the day of treatment.** Since your insurance company may not cover all costs, we require that you pay any percentage of your balance not paid by your insurance on the day of treatment.

*** For services that are not covered by your insurance, we require that you pay the entire fee the day of your treatment**

***** We will attempt to answer any questions we can about your insurance and, to the extent practicable, assist you with insurance billing issues. However, your insurance contract is an agreement between you and your insurance carrier to which we are not a party. In the event that your insurance company does not pay any amounts due for your care, you agree you are financially responsible for such amounts, and that you will pay such amounts due for your care.

Patients Without Insurance

*** For those patients without insurance coverage, you will be responsible for payment on the day of treatment.** If you are not able to pay in full, or if your treatment requires several visits, you will be issued an invoice and will be able to discuss payment arrangements with a member of our business office staff.

Cancellation/No Show Policy

***** Our office requires at least 48 hours advance notice to cancel your appointment in the case of an emergency.

*** We reserve the right to charge a reasonable fee, up to the amount normally due for our services, for patients who do not give advance notice to cancel an appointment.**

Collections

***** A charge will be added to your account for any returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on your account including all attorneys' fees, interest, and late fees.

X-Rays

***** You are responsible to pay a fee for duplicate copies of your X-rays.

I hereby authorize payment to Zhukovsky Dental Clinic by my insurance company, otherwise payable to me.

Patient Signature: _____x **Date: ____/____/_____**