FRED S. MARON, D.M.D.
541 Haight Avenue
Poughkeepsie, New York 12603

FINANCIAL POLICY

FOR THE ACCOUNT OF (responsible party) _____

PLEASE LIST ALL FAMILY MEMBERS UNDER THIS ACCOUNT _____

NAME _____ **PHONE** _____
(LAST) (FIRST) (MI) (HOME) (WORK) (CELL)

ADDRESS _____
(STREET) (APT) (TOWN/CITY) (ZIP)

EMPLOYER _____ **DENTAL INSURANCE CO.** _____

GROUP #_____ **S.S.#/ INS. ID#** _____ **E-MAIL** _____

METHOD OF PAYMENT: PLEASE CHECK ONE OPTION

☐ **OPTION 1: Payment in full at each appointment**

☐ **OPTION 2: Payment at each appointment of estimated amount not covered by insurance**
(Option 2 available *only* with a credit card number on file)

I am aware if the insurance company leaves the account with an unpaid balance, any remaining balance owed for me or a family member under this account will automatically be charged to my credit card or debit card. If the credit card has expired or has unavailable funds the account will be in default, and I will be responsible for a late fee of $5.00 per month. If payment is made by check and the check is returned, a fee of $25 will be charged to my account. If the account is sent to a collection agency, I will be responsible for all collection charges incurred by the dental office.

☐ Visa ☐ MasterCard ☐ Discover ☐ Care Credit

Credit Card □□□□-□□□□-□□□□-□□□□ **Exp. Date** □□-□□ **Security Code** □□□

AUTHORIZATION OF INSURANCE:

I hereby authorize payment directly to the dental office of Fred S. Maron of the insurance benefits otherwise payable to me.

NOTES ON INSURANCE:

Our office is willing to wait 75 days to receive payment from your insurance company. (New York State law requires the company to pay in 45 days!) However, the insurance company knows that the longer it delays payment, the more interest it makes on your money. The insurance companies respond much more quickly to calls from patients or their employers as you and your employer pay the premiums. Therefore, when insurance companies deny or delay payment and need more information, we will promptly forward these requests to you. If the insurance company does not pay the claim within seventy-five days (75) after treatment, then the amount owed will automatically be charged to your credit card. Any payment received from the insurance company after charging your credit card will be refunded to you.

BROKEN APPOINTMENTS:

I am aware that a **$25** fee is charged when I, or a family member does not attend a dental appointment and does not give the office adequate notice of a cancellation. **OUR OFFICE DOES NOT CALL TO REMIND YOU OF YOUR APPOINTMENT. A NON-REFUNDABLE DEPOSIT MAY BE REQUIRED TO SCHEDULE AN APPOINTMENT.**

ACCOUNT CHANGES:

I am aware that any changes made to this account must be given in writing one week prior to a scheduled appointment for me or a family member.

Signature _____ **Date** _____

I understand and agree to this Financial Policy and authorize payment of any unpaid balance with the charge card listed above.