

ROBERT A. WEINTRAUB, D.M.D.

OUR FINANCIAL POLICY

Thank you for choosing us as your dental healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Payment options are:

1. Co-payments and/or Full payment is required at the time of treatment.
2. We accept Cash, Checks, Visa, MasterCard and/or Discover.
3. If case treatment is paid in full before treatment is started you will be granted a book keeping courtesy of 7% for cash/check and 5% for credit card payments.
4. Interest free loans up to 12 months are available through Care Credit or CitiHealth

As a courtesy we will submit insurance claims on your behalf and we will wait up to 45 days for payment. After that, we will expect full payment from our patients. After 90 days there will be a 1.5% finance charge on all unpaid balances.

INSURANCE

We will accept assignment of insurance benefits however we do require the estimated co insurance portion of the bill to be paid at the time of treatment. The balance is your responsibility whether your insurance company makes payment or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some services rendered may be non-covered services.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Credit card, or payment by cash or check at the time of treatment has been verified.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit (\$55). Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. By signed below you have agreed that you have read, understand and agree to our Financial Policy.

X _____ Date _____
Signature of Patient and/or Responsible Party