FINANCIAL POLICY AND RELEASE BENEFITS

We are committed to providing you with the best possible care, and 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. Feel free to ask about our fees, Financial Policy, or your responsibility.

IF YOU HAVE INSURANCE

Dental insurance is a contract between you and your insurance company. It is your responsibility to understand the extent and limits of your coverage, and to provide our staff with accurate information to process your claim efficiently (i.e. insurance company address, phone number, etc.). It is not our place to enter into disputes between you and your insurance company regarding deductibles, copayments, etc. other than to provide factual information. We do not directly participate with most Insurance programs; however, as a courtesy, we do process your claim for payment to be made directly to you. Certain conditions may apply to your financial arrangements that may require your authorization for release and assignment of benefits. Your signature below authorizes us to offer this when it applies to your situation. If we do not participate with your insurance, 100% of the total cost is requested at the time of treatment. If you are unable to pay 100%, affordable payment options are available. Our staff will help you process whatever paperwork is required. However, the ultimate responsibility lies with you for payment of any and all monies due.

MISSED APPOINTMENT

I, the patient, agree to arrive on time for my appointment. I understand that this time is reserved especially for my benefit. I understand that without 24 hour notice of a cancellation, I will compensate Dr. Peter Hazim $65 for time lost on my account.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT

RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize this office to release to your benefit program or its representative any information including the diagnosis and the records of any treatment or examination rendered to me. I authorize, if applicable, payment to be sent to this office.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED

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Signature of Responsible Party **DOB** **Date**