Robert S. Dolgow, D.D.S., P.A.
Constantin Fiacos, D.M.D., P.A.
MASTERSHIP ACADEMY GENERAL DENTISTRY

Family & Cosmetic Dentistry

Located in The Super Target Center
7752 W. Commercial Blvd. · Lauderhill, FL 33351-5095
(954) 741-4500
Fax: (954) 741-4797

FINANCIAL POLICY

In the interest of good health care practice, it is best to establish a policy to avoid misunderstandings.

Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy towards that end. Therefore, we wish to clarify the following points:

1. All accounts are due and payable at the time of your visits unless satisfactory arrangements have been made with our office manager.
2. Even though you may have an insurance claim pending you will receive a statement each month for the outstanding balance of your account. We cannot accept responsibility for collecting and insurance claim or for negotiating a disputed claim. *(Insurance reimbursement is a contract between you and your carrier. You are responsible for payment of your account within the usual limits of our credit policy.)*

FINANCIAL OPTIONS

I,_____ choose the following method of payment for my dental care and the care of my dependents.

Please initial your preferences.

I. I have no dental insurance.

A. A bookkeeping courtesy for payment in full if I elect to pay by cash ___ or check ___ .

B. Visa ___, MasterCard ___, Discover ___, on all visits as treatment progresses.

C. I elect to pay by **CareCredit** ___ . **CareCredit** is a payment plan in which I can receive up to One year interest free payments.

D. On extensive treatment, I elect to pay half on the preparation date and the balance in three equal payments.

E. I prefer to secure a bank or credit union loan for the entire amount and make monthly payments to my lending institution over an extended period of time.

II I have dental insurance through _____

A. I elect to pay my deductible of $_____ , and any uninsured portions at time of service.

B. On treatment amounts over $ 200.00 , I elect to pay 50% of my uninsured portion on the preparation date and the balance on completion or delivery date.

C. On treatment amounts over $ 200.00 , I elect to pay 50% of my uninsured portion on the preparation date and the balance in three equal monthly payments.

I have read this Credit Policy and understand that, regardless of any insurance coverage I may have, I am responsible for payment of my account with the usual limits of this Credit Policy. I agree that in the event costs and/or fees are incurred in connection with the collection of my account, I will pay all such costs and fees, including collection costs attorney's fees and all court costs.

Date: _____ X _____
Party Responsible For Account

_____ _____
Financial Manager