Drs Stadelmann and Gulino Inc.

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being as comfortable and successful as we can provide. Please understand that payment for services rendered is 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.

FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS
PRIOR ARRANGEMENTS HAVE BEEN MADE.
We accept CASH, CHECKS, VISA, MASTERCARD, AMEX and DISCOVER.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not part of that contract. You are responsible for the payment of services provided to you by the doctor. We will fill out the provider section of your claim form and submit the claim in your behalf at no charges. You must provide us with the appropriate information so that we may help you receive the maximum possible benefit from your coverage. Plans where we are participating, we agree to abide by the terms of our contract with the carrier. All co-pays and deductibles are due as services are rendered.

ESTABLISHED PATIENTS: May assign benefits to the office is a prior authorization and estimate of benefits has been received prior to treatment. A consultation and pre-determination is required prior to treatment. Please be aware that some, and perhaps all the services provided may not be covered under your insurance policy. It is important that you read and understand your policy. Your carrier can only provide specific answers as to the extent of coverage and reimbursement schedules.

PAYMENTS ARE ALWAYS DUE IN FULL FOR CONSULTATIONS.

USUAL AND CUSTOMARY RATE (UCR): Our practice is committed to providing the best treatment for our patients and we charge our patients what is reasonable and customary in our area for that level of service. Insurance carriers determine their own UCR, which may not match our office UCR. You are responsible for payment of our office fees regardless of the insurance company's arbitrary determination of UCR.

A notice of 5 business days is required for appointment cancellation.
Failure to comply will result in a $50.00 cancellation fee.
An office charge of $25.00 plus any bank fees charged to this office will be applied to all NSF check.

Thank you for understanding our financial policy. Please let us know if you have any question or concerns.

I have read and understand this financial policy. I understand my insurance as it relates to my treatment. This signature acts as my permanent insurance signature and allows the release of records to the insurance company and direct payment of insurance to the doctor's office. When applicable it is this office policy to charge a finance fee of 1.5% per month on balances outstanding more than 30 days (18% interest per year). If my account must be turned over to an attorney for collection, I will be held responsible for legal and collection fees. I understand the term and agree to abide by this policy.

DATE _____ SIGNATURE OF PATIENT or RESP. PARTY_____
If you are paying by check we require a valid driver's license # _____ State_____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being as comfortable and successful as we can provide. Please understand that payment for services rendered is also part of your treatment.

We require you to read and sign prior Financial Policy before any treatment is performed.
We accept Cash, Checks (with a valid driver's license on file) Visa, Mastercard, American Express, Discover and Care Credit.
In the event a balance is due after insurance payment, consent is given to use any previous credit /debit card on file to pay your balance off to zero balance.

DENTAL INSURANCE: Your dental insurance policy is a contract between you and your insurance company. *We are not part of that contract.*
You are responsible for payment of services provided to you by the doctor on the day services are rendered.
We will file your claim form and submit the claim in your behalf at no additional charge.
You must agree to provide us with the appropriate information asked by our dental staff so that we may help you receive the maximum possible benefit from your coverage. Please be aware that some and not all services will be covered under your insurance policy.
Plans where we are a participating provider, we agree to abide by the terms of our contract with the carrier. Dental plans that will only reimburse the subscriber directly will be filed on your behalf but payment in full will be paid prior to your dental treatment being performed by the doctor.

MEDICAL INSURANCE:
We do not participate with ANY medical plans. Therefore, you must pay on day of service in full as any claims submitted on your behalf depending on your treatment (if applicable) will be paid to us as an out-of-network provider.
Medicare does not cover tooth extractions. We will provide you with a statement if you wish to pursue reimbursement from your medical carrier. *All insurance companies quote us the terms of your policy, however payment is not guaranteed until your claim is actually submitted and reviewed by your insurance carrier's reviewers for determination of payment.*

Your estimate will be based on your insurance policy and any payment due after your insurance has paid a benefit to us on your behalf is due upon receipt of our statement to you.

CO-PAYS AND DEDUCTIBLES ARE DUE AT TIME SERVICES ARE RENDERED

We also reserve the right to assess a cancellation fee for broken appointments without a prior two (2) day notice. I have read and understand this financial policy. This signature acts as my permanent insurance signature and allows the release of records to the insurance company and direct payment of insurance to the doctor's office. It is also the office policy that a finance charge will be assessed of 1.5% per month on balances more than 30 days (18% interest per year). If your account is forwarded to our attorney for collection, any applicable legal and collection fees will also be your responsibility to pay. I understand this policy and I agree to abide by this policy.

Patient / Guardian Signature: _____ Date: _____