Classi Smiles
EXCELLENCE IN COSMETIC & IMPLANT DENTISTRY

800B 5TH AVENUE, SUITE 2 NEW YORK, NY 10065 · 212.682.3313

# OFFICE POLICIES

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our Office Policies.

**1. VERIFYING INSURANCE: As a courtesy to you,** we will verify your insurance for eligibility benefits prior to your new patient appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. **You are ultimately responsible** for knowing if there are any waiting periods for work to be performed. Any amounts on your treatment plans that are not covered by your insurance are your financial responsibility.

**2. PAYMENT:** Payment is due **at the time of service.** Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.

**3. INSURANCE INFORMATION: New Insurance** as well as **changes in INSURANCE** must be provided to this office prior to an appointment. Failure to provide correct and current insurance information may result in the entire bill being **your** responsibility.

**4. CHANGES IN PERSONAL INFORMATION:** Changes in your address or telephone numbers should be kept current with our office.

**5. REQUESTS FOR ADDITIONAL INFORMATION:** These must be responded to **immediately.** Such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being your responsibility.

**6. PAYMENT PLANS:** Our office offers Third Party Financing if needed to assist you in paying for any necessary treatment.

**7. BALANCES:** If your account balance exceeds 90 days, you will receive a notice informing you that your account is **overdue and a $50 collections surcharge may be added to your account.** If you do not pay your balance or arrange a payment plan within 30 days, your account will be turned over to a collections agency. If this happens, the collections agency will report any unpaid balance to the major credit bureaus.

**8. RETURNED CHECKS:** There will be a **$30** fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash, or credit card. Once a check has been returned, this office will no longer accept personal checks for payment.

**9. CANCELLATIONS** / **FAILED APPOINTMENTS:** We request **24-hours notice** if you are cancelling an appointment.

I believe that I may have a condition requiring dental care, I do, as a condition of my treatment hereby voluntarily consent to such dental care at **Classi Smiles** ("Office") encompassing diagnostic procedures and dental treatment (including medication) by members of the dental staffs of the Office designees as is necessary in their judgment of those involved in treatment.

I understand that emergency care is available twenty-four hours per day.

I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in the Office.

Thank you for reading this information in full. Please sign below to acknowledge your understanding of our office policy and consent for treatment.

PATIENT OR GUARDIAN SIGNATURE _____

PATIENT NAME (PLEASE PRINT) _____

DATE _____