

YOSOPAKOYUT DENTISTRY

Phone: (718) 554-7798

1201 Ocean Parkway Brooklyn, NY 1230

Our Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we have found helpful to our patients in knowing exactly what dental financial responsibilities they will incur.

Insurance and Usual & Customary Fees

Our office understands the value of insurance benefits to our patients. We will file your insurance at no charge. Please understand that dental insurance is a contract between the patient and the insurance carrier, not between the dentist and the insurance carrier. NO insurance company will cover 100% of all dental expenses. All fees, including deductible and co-pay, are due at the time treatment is performed.

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

We will do all we can to assure you of maximum benefits. However, there are no guarantees of payment from any insurance company and payment for dental services is the patient's responsibility.

Delinquent Accounts

We reserve and will exercise the right to turn over any account more than 90 days past due to a collection agency. Any expenses incurred as a result of this are the patient's responsibility, as permitted by law.

Missed Appointments

Appointments are valuable blocks of time. When an appointment is broken or cancelled with short notice (less than 24 hours), we are prevented from helping other patients. Wasted appointment times also result in higher healthcare fees. **In order to control dental costs for our patients, we will charge a non-refundable \$54.00 cancellation fee for all appointments that are broken or cancelled with less than the required 24-hour notification (unless special circumstances prevail).** Please help us control costs as well as serve our patients better by keeping all scheduled appointments.

I have read the Financial Policy. I understand and agree to the Financial Policy.

X

Signature of Patient or Responsible Party

Date