Lillian Vidal D.D.S., LLC
1 Engle Street
Englewood, New Jersey 07631
201-227-0516

Financial Policy

Thank you for choosing our office for you dental needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete a patient history and inform our office of insurance before seeing a doctor. Full payment is due at time of service. We accept Cash, Visa/Master Card and Discover Card as forms of payment. Any return checks will be subject to a $25.00 bank return fee.

Regarding Your Insurance

As a courtesy to our patients we will bill your insurance company for your reimbursement, but please note that we cannot bill your insurance company on your behalf unless you give us your insurance information and a copy of your insurance card**. Your insurance Policy is a contract between you and your insurance company; we are not a party of that contract**. **Please be aware that some and perhaps all of the services may be non-covered services according to your carrier.**

Regarding Payment of Dental Services

Payments for all services are paid out as follows:

1. For all general treatments which include, Operative work (Fillings), Sealants, Emergency, Recalls, Perio Maintenance, Diagnostic, Radiographs and Consults payment in full is expected on day of service.

2. Prosthetic Service which includes Crowns, Bridges, Dentures, Onlay/Inlays and Implants, a 50% deposit will be required at the initial visit; the remaining balance will be divided into the number of visits needed to complete your treatment. **(Note: Full remaining balance is required by the date of insert).**

3. Although we are currently a Delta Dental PPO and Horizon Blue Cross – Blue Shield of New Jersey (Traditional Plan Only) provider, you as the patient may be responsible for some or all of the non- covered services according to your insurance carrier. Participants of such plans must come prepared to pay in full on the date of service your obligations for each service rendered. Late Charges. Interest Charged on Unpaid Balance.

Bills for our services and costs incurred on your behalf will be submitted to you no less frequently than monthly. Our bills are payable upon receipts. If your monthly bill remains unpaid for **30 days**, you will be charged a late fee equal to **6%** of the full amount then past due. In addition to such late fee, an administrative charge shall be imposed on all past due balance which shall be calculated at the rate of **20%** per annum **(1.67% per month), until full payment is made.**

Failure to Pay; Casts of Collection; Attorney's Fees

If you do not pay your bill(s) or any portion of your bill(s) rendered in accordance with this Agreement, we may file a lawsuit against you. If we file a lawsuit, you shall also be responsible for paying all court costs and reasonable attorney fees. It is agreed that reasonable attorney's fees shall be deemed to be equal to 25% of the total outstanding balance of your bill, inclusive of any late fees and interest.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates**, (with the exception of Delta Dental and Blue Cross- Blue Shield Traditional).**

Adult Patients

Adult patients (18 years or older) are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardian of the minor) is responsible for full payment. For unaccompanied minors, treatment will be denied**.**

Missed Appointments

As a courtesy, our office confirms 2 days prior to each scheduled appointment. Please note that it will be each patient's ultimate responsibility to notify our office within **48 hours** in the event that an appointment may need to be rescheduled. Unless cancelled at least **48 hours** in advance, our **strictly enforced** policy is to charge for missed appointments at the rate of a normal office visit **($85.00).** Please help us serve you by keeping scheduled appointments.

I, ___________________________ understand that if I am delinquent on my obligation to pay Lillian Vidal D.D.S., LLC, then I will be responsible for any late fees, interest

charges, court costs, attorney fees, and collection charges should the balance not be paid in due diligence.

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

I have read the financial policy. I understand and agree to this financial policy.

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Signature of patient or responsible party Date