FINANCIAL POLICY

JEANNE ANNE KRIZMAN, DMD, PLC

Thank you for choosing our office for you dental needs. We are committed to provide the highest quality of dental care available to all our patients and to have those services comfortably affordable, we are pleased to offer you options for payment. The following is a statement of our Financial Policy which must be reviewed and signed.

INSURANCE

As a courtesy, our office will provide you with the proper dental codes so that you may submit your insurance claims independently. Our patients generally receive reimbursement from their insurance carriers in 2-3 weeks. We are out-of-network providers and therefore have no connection to your insurance plan.

PAYMENT

PA YMENT IS DUE WHEN SERVICES ARE BEING RENDERED. Ours is a small office and we depend on our patients paying the agreed fee when services are rendered. If you cannot pay at the time that service is rendered, you must make alternate arrangements acceptable to us before treatment begins.

PAYMENT OPTIONS

We offer the following payment options:

Cash or Check Payment

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Visa, Master Card, American Express, Discover, Debit.

No Interest Payment Plan with Care Credit (OAC). If you intend to pay by OAC, you must make arrangements acceptable to us before treatment begins.

RETURNED CHECKS

A $25.00 returned check fee will be billed for any returned checks.

ACKNOWLEDGMENT

Thank you for understanding our Financial Policy. We are here to assist you in any way possible. Please make your questions and concerns known to our team as our goal is to ensure that you have an outstanding experience. I have read the Financial Policy. I understand and agree that:

I understand that my insurance is a contract between me and my insurance company and that Jeanne Anne Krizman DMD, PLC does not file insurance claims for you. I understand that Dr. Krizman is not in network with my insurance and authorize payment from my insurance will be paid directly to me. I understand that Jeanne Anne Krizman DMD, PLC is a fee for service dental-care provider. I understand that insurance is not a guarantee of payment.
Signature of Patient/Responsible Party:_____ Date:_____

PATIENT APPOINTMENT POLICY

Dear Valued Patient,

Our purpose is to help our patients keep their teeth and gums healthy for life. Proper scheduling of appointments is vital to this endeavor. Therefore, we ask for your cooperation regarding the following appointment policy:

1.) Every effort is made to keep on schedule so we respectfully ask patients to be prompt and keep their appointments. We try to remind patients by telephone prior to their appointment, but please do not depend on this courtesy. If we are unable to reach you, your appointment card/invoice printout will serve as the confirmation of your appointment and implies your obligation and agreement to be present at the appointed time. That time has been reserved especially for you. This means no other patient has been scheduled for that particular time slot and chair, and that anyone else wishing to schedule for that time has had to be given a different time for their appointment. We reserve the right to charge for office visits cancelled or broken with less than 2 business days advance notice (e.g. if your appointment is scheduled for Monday at 3 P.M., and you need to re-schedule, you must call us before the prior Thursday at 3 P.M.). Exceptions to this policy can be determined only on an individual basis according to the circumstances. The broken appointment charge will depend on the procedure and time reserved, but will start at $50 per hour for the hygienist and $100 per hour for the doctor.

2.) In order to ensure that we keep to our schedule, and yours, as much as possible and to minimize patient waiting time, it is necessary to schedule certain procedures for specific times during the day. This allows us to provide you with the excellence in care that you expect and deserve. We know that your time is valuable and that none of our patients want to spend any longer in the dentist's office than they have to. Scheduling specified procedures for specific time slots allows us to be more efficient with your treatment and actually minimizes the time you have to spend at our office.

If you have any questions about this policy, do not hesitate to ask our office staff. We believe that good communication is key to providing you with quality dental care.

Patient Printed Name: _____

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Patient Signature: _____ Date_____

OR

Signature of Parent or Responsible Party_____ Date_____

Relationship to Patient_____