LESLIE G. PLATOCK, D.D.S.

COSMETIC AND GENERAL DENTISTRY

Financial Arrangements and Dental Insurance

We are committed to providing you with the best care possible. If you have dental insurance we will do our best to help you receive the maximum allowable benefits.

It is our policy that you pay your deductible and/or your co-payment at the time of your visit. We accept cash, checks, care credit and most major credit cards. We will bill you any unexpected balance not covered by your insurance plan.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance the best we can.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company.

2. Insurance carriers have predetermined fee allowances (UCR-"usual and customary, reasonable") for dental procedures. As dental providers, we do not have access to these UCR fees, or any influence in changing them. **Any co-payment quote offered by our office is strictly an estimate. We make no guarantee regarding anticipated insurance payments.**

3. As dental care providers, our relationship is with you, not your insurance company.

There is a $30.00 processing charge for non-sufficient funds or returned checks.

To cancel or reschedule an appointment, you must give our office at least 24 hours' notice in order to avoid being charged a $7**5.00 charge fee.**

Assignment of Insurance Benefits and Authorization for Treatment

- ❒ I authorize other health care providers to release pertinent dental information to Leslie G. Platock, D.D.S.
- ❒ I authorize the release of dental information to my referring doctor(s).
- ❒ I authorize the release of dental information to insurance carriers.
- ❒ I am financially responsible for any balance due, including collections or broken appointment fees.
- ❒ I authorize my insurance benefits to be paid directly to the doctor, Leslie G. Platock, D.D.S.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date of the services that are rendered. We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Patient (parent or guardian if patient is a minor) Print Name: _____

Signature: _____ Date _____