

Smiles of Skaneateles  
P. Gard Lorey, DDS & Sean P. Smith, DDS, PC  
1579 Cherry Valley Turnpike  
Skaneateles, NY 13152  
Office (315) 685-5874 - Fax (315) 685-1814

### Financial Policy

We are committed to providing you with the best possible care. We never want finances to stand in the way of your overall dental health therefore; we have many different payment options. If you have a dental benefit plan, we are anxious to help you receive your maximum allowable benefits but will never base your dental needs or our recommendations on what your benefit plan is willing to cover.

In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment or co-payment is due at the time services are rendered. We accept cash, checks, Visa, MC, and Discover. We will be happy to process your insurance claim for both your primary and secondary plans providing we have all the information in order to do so.

We will gladly discuss your proposed treatment and answer any questions you may have. You must realize however that:

1. We will be happy to work with your insurance company to obtain maximum benefits. We recommend you arrive at treatment decisions based on what is best for your overall dental health, not solely on what your benefit plan is willing to cover. Remaining balances not covered by your benefit plan are your FULL responsibility.
2. Because insurance policies vary greatly, we can only ESTIMATE your coverage in good faith but cannot guarantee coverage due to the vast amount of insurance companies we deal with and the complexities of contracts. If you would like to know your exact insurance benefit, we will be happy to send a pre-determination of benefits to your insurance company upon your request.
3. While the filing of insurance claims is a courtesy that we extend to our patients, all charges remain your responsibility from the day of services rendered.

We must emphasize that as dental care providers our relationship is with you. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

We will be asking on the day of your appointment for your full payment or co-payment for services rendered, as well as any outstanding balance on your account. For any extensive procedures, we will continue to make financial arrangements prior to the day of service. Please let us know if arrangements need to be made before you come in for your appointment.

On procedures over \$500, a pre-payment courtesy of 5% will be granted to anyone who schedules an appointment for their needed dental care within 48 hours of the recommendation by the doctor and pays in full upon scheduling. Failure to keep this appointment or change it with less than 24 hours' notice will void courtesy and that amount would be re-applied to the account. We also offer a 3% courtesy for any account paid in full on the day of service. Insured patients who wish to take advantage of this courtesy will need to pay us in full, then allow your insurance company to reimburse you directly for their portion of payment.

If the full payment discount is not something you would like to take advantage of, we will work out a payment plan for any major work. For any payment plan to be implemented, 1/3 of the total fees must be put down on the day of service. Payment plan lengths will range from 3 to no longer than 6 months. The only exception would be for orthodontic cases that take 12-24 months for us to complete.

Regarding appointments and service fees, please realize that a specific amount of time is reserved especially for you. If you must change your appointment, we will require at least 24 hours' notice. Also, we reserve the right to charge a returned check fee and well as late fees up to and including, but not limited to: late payment fee, cancellation fee, broken appointment fee, etc.

Our Financial Coordinator will be happy to assist you with any questions you may have. We look forward to seeing you at your next visit.

I have read, understand, and agree to adhere to the above stated policy.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date