Office Policy

Please read and sign on the back, acknowledging that you were informed of these policies. Thank you.

Financial Policy

Thank you for choosing **Dr. Michael Vanaria** to service your dental care needs. We provide high-quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is considered a part of your treatment. In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. To assist our patients, we offer the following methods for taking care of their account in our office.

→ Before or on your first visit we expect you to supply our office with your insurance information. If any changes should occur during the time you are a patient, it is your responsibility to inform our office with any changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.

→ Patients are required to pay their deductible and co-payments at the time of each visit.

→ While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and be aware of services covered or not covered by your individual plan.

→ As a courtesy, we will gladly bill your insurance when you provide us with the information and any necessary forms. Often times we are able to contact your insurance provider prior to your appointment, and estimate your portion of the bill. We ask that you pay your portion of the bill at the time of service. Insurance policies are a contract between you, your employer, and the insurance carrier. Please be aware that some, and perhaps all of the services rendered may not be covered under your individual insurance policy. You are ultimately responsible for payment of your account.

→ If no payment is received on an account after two monthly statements our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating that "This will be the final notice for payment". If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency.

Failed or Cancelled Appointments

We confirm all appointments the day before your scheduled time. Please be aware that a missed appointment hurts 3 people; you, the doctor, or hygienist, and the person who could have used the time. A cancellation charge will be made for broken appointments unless 24 hours notice is given to cancel or change same. The length of time reserved and the number of prior failed appointments determines your charge. We will not offer appointments to patients who fail multiple appointments without having given us proper notice.

Estimates and Fees

After x-rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time of diagnosis; unforeseen circumstances, such as pulpal therapy or cracked teeth could alter an estimated fee. It is customary to pay for dental services when they are rendered.

Delinquent Accounts

Delinquent accounts will have to be turned over to a Credit Reporting Collection Agency.

Notice of Privacy Practices (HIPAA)

A laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations. We encourage you to read it carefully and completely before signing this Consent.

Turn over

Authorization for Signature on File

Release of Information/ Financial Responsibility/ Authorization for Payment

I hereby authorize **Dr. Michael Vanaria** to affix my name to any and all claims or documents as related to any and all health benefits or me and my dependents. I herby authorize payment of dental benefits otherwise payable to me directly to the office above. I agree o be responsible for all charges for dental services and material not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to the claim.

Signature of Patient: _____Today's Date: _____
(Parent or Guardian if minor)

*This "Authorization" will be valid from this date and shall expire in one year.

*A photocopy of this document may act as an original.