MARINI & MANCI DENTISTRY
COSMETIC ■ IMPLANT ■ RESTORATION

☐ 21 Spring Street
New York, NY 10012
P.212-226-1666
F.212-966-2645

☐ 602 15th Street
Union City, NJ 07087
P.201-864-8510
F.201-864-0990

Dr. Joseph S. Marini
Dr. Gary M. Manci

## THE FINANCIAL ASPECT OF YOUR DENTAL TREATMENT

Our primary goal is to provide patients with the highest level of dentistry available, using the latest techniques and materials to ensure both long lasting and beautiful results. We realize that this needs to be accomplished while keeping your budget in mind. All costs for your dental care will be discussed in detail so you may plan your budget accordingly for your treatment.

- **INSURANCE**: As a COURTESY TO YOU, we will bill your dental insurance carrier, but we require that you pay the estimated copay at the time of the service. In some cases, your insurance carrier will only send payment directly to you. In this instance, you must pay in full for your treatment at the time it is performed, and we will submit the paperwork to your carrier for your direct reimbursement.

  We will attempt to estimate how your insurance company will pay for your dental services, but we have no way to guarantee what your carrier will pay. **Please be advised that if your carrier is to pay our office directly and that payment is not received within 90 days, then that amount will automatically become your responsibility**. This amount will be billed to you and is due upon receipt of statement.

- **APPOINTMENTS**: We will make every effort to schedule your appointments at times that are convenient for you. Both appointment times and appointment lengths are customized according to your needs. When you make an appointment, please keep in mind that **we are reserving that time especially for you**. We respect your valuable time, and we ask the same respect of our patients. Cancellations must be made at least 24 hours prior to a scheduled appointment or it may result in a charge corresponding to the length of the missed appointment.

- **PAYMENT OPTIONS**:
  **A**. Payment in full at time of service by check or cash.
  **B**. Payment in full at time of service by Visa, MasterCard Discover or American Express.
  **C**. Arrangements through an outside financial institution, including no-interest payment installments. Our staff will provide you with the information to utilize this simple payment option for dental treatment.

- **AUTHORIZATION**
  I understand that I am responsible for the total cost of my dental treatment, and I authorize payment of dental benefits directly to this office. I hereby authorize this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information I have provided to this office on this form, and on any other form completed and signed by me, is correct to the best of my knowledge. I will not hold Marini and Manci, D.M.D., P.A. or any member of the staff responsible for any errors or omissions that I may have made in the completion of my medical or insurance information.

- **FINANCE CHARGE**
  If I do not pay the entire new balance of my account within 60 days of the billing date, a Finance Charge of 1.5% will be added to the account for each monthly billing period. In the case of default of payment, I promise to pay any interest accrued on the balance due, along with any collection costs and reasonable attorney fees incurred in the settlement of the account.

**I understand and agree to the above** _____ **Date:** _____
(Patient/Parent/Guardian)

Best time to be reached by phone: Morning ( ) Afternoon ( ) Evening ( )

I can best be reached: Home # _____ Work # _____ Mobile/Beeper # _____