MARGARET ROMEO, DMD, PA
FINANCIAL POLICY

Patient Name _____

Name of person responsible for account _____

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available today.

All charges you incur are your responsibility regardless of your insurance coverage. As an out-of-network dental care provider, our relationship is with you, our patient, not with your insurance company. Your policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. We file insurance as a courtesy. This does not release you from your ultimate financial obligation. By signing the Registration Form you authorize the insurance company to pay benefits directly to us (insurance permitting).

(initials) _____

You will continue to receive a bill as long as there is a balance on your account. You remain fully responsible for the entire amount of the bill. Your account may be sent to a collection agency if not paid in full within 120 days (4 months). **If sent to a collection agency, a collection fee of an additional 30% will be added to your bill.**

(initials) _____

Payment is due at the time of service. Our office accepts cash, personal checks, MasterCard, and Visa. Outside financing (payment plan) is available through *CareCredit* upon request and approval.

Returned checks are subject to a collection fee of up to $50.00.

(initials) _____

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, applicable co-payments and deductibles are my responsibility. I understand that failure to pay my account may result in my account being forwarded to a collection agency and restrictions on scheduling future appointments.

_____ _____

Patient or responsible party signature Date

_____

Witness Signature

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