Periodontal Associates
PERIODONTICS | DENTAL IMPLANTS | BONE REGENERATION

Cary N. Feuerman, DMD
Giovanni Castellucci, DMD

Financial Policy

Full payment for treatment is required on the day that treatment is provided.

Periodontal Associates accepts several forms of payment for dental treatment provided at our offices:

Cash, debit card, personal check, business check (by an authorized person)
Credit Cards*:* MasterCard, Visa, Discover, American Express

***Dental Insurance*:**
Periodontal Associates has a working relationship with most dental insurance carriers, including MetLife, Aetna, Guardian, Delta Dental and Blue Cross Blue Shield. Patients with insurance coverage will be required to make payment in full for treatment on the day of service unless the patient has made other arrangements with our Financial Coordinator prior to treatment. As a courtesy to our patients, Periodontal Associates will submit a claim to the patient's insurance carrier and **any reimbursement will be made by the carrier directly to the patient**.

Understanding your insurance coverage can be quite a challenge. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments. Our goal is to assist you in understanding and maximizing your benefits.

Our courtesy service to you includes:
1) Filing pre-estimate requests to predetermine the benefits you can expect to receive for your treatment.
2) Filing your insurance electronically, or by mail (paper claim), within 24 hours of service.
3) Following American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:
1) Payment of fees at time of treatment, as outlined above.
2) Please understand that the insurance policy belongs to **you** and that the obligation for payment remains solely that of the patient or responsible party.
3) Please realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called UCR), and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, *not* our fees or recommended treatment.

I hereby authorize Periodontal Associates to release to my insurance company all information that is required to properly process my dental claims. I have read and understand the above stated financial policy. I understand that I am responsible for all charges associated with this account and that interest charges of 1.5% per month will accrue on unpaid balances.

_____ Date _____
Responsible Party Signature

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