Allyson A. Abbott, D.M.D.
Christian J. Lehr, D.M.D.
Tina Chou, D.M.D.
Ivan Miloradovic, D.M.D.

Practice Limited to Endodontics

Financial Agreement

We, the staff of Allyson A. Abbott, DMD, PC thank you for choosing us as your endodontic provider. We are committed to providing you with the highest level of care and to building a successful provider- patient relationship with you. We believe your understanding of our patients' financial responsibility is vital to that provider- patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have questions of concerns regarding our fees, policies, or responsibilities, please feel free to contact our office manager at 610-834-7770. We believe this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients.

Patients without Dental Insurance:
Payment for treatment is due at the time of service. For your convenience, we accept cash, check, Visa, MasterCard, American Express and Discover. Please be aware we do not accept Care Credit. If you are unable to make payment in full at the time of service this must be discussed **prior to your appointment date** with the office manager.

Patients with Dental Insurance:
Please remember that your insurance policy is a contract between you and your insurance carrier. We do submit claims electronically to your insurance carrier for reimbursement towards your account, as a courtesy to you. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. If your insurance company reimburses you directly, we will file your claims but require payment in full for your treatment at the time of service, unless financial arrangements have been made **in advance** with the office manager. Patients are responsible for any balances not covered by dental insurance. Any outstanding account balances not paid by insurance within 60 days becomes the responsibility of the patient. By signing this form you agree to provide all relevant and accurate information to facilitate the prompt payment of the claim by your insurance company. Our office staff will verify your insurance details, your estimated patient portion is due in full at the time of service. Failure to provide all required information may necessitate patient payment for all charges.

Office Policy
1. A $75.00 fee will be charged for any missed appointments without at least 24 hours' notice. If you are scheduled for a Monday, we must be notified by 10am, on the Friday prior to your appointment if you wish to cancel.
2. All checks returned from the bank are subjected to a $35.00 service fee.
3. Accounts delinquent more than 30 days from the date of billing are subject to a finance charge per month.
4. Accounts delinquent more than 120 days may be sent to a collection agency for settlement and you will be responsible for any additional fees.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES

Signature:_____Date:_____