

VALLEY DENTAL PEDIATRICS  
609 EAST MAIN STREET  
ENDICOTT, NY 13760  
(607) 754-3903

## FINANCIAL POLICY

**PAYMENTS:** FEES FOR TREATMENT ARE DUE IN FULL AND PAYABLE AT TIME OF SERVICE. FOR YOUR CONVENIENCE, WE HONOR MASTER CARD, VISA, AND DISCOVER CARDS AS WELL AS CASH OR PERSONAL CHECKS.

**PAST DUE ACCOUNTS:** A FINANCE CHARGE OF 1.5% PER MONTH OR 18% PER ANNUM IS APPLIED TO ALL BALANCES OVER 30 DAYS PAST DUE WITH A MINIMUM CHARGE OF \$.50. SHOULD YOUR ACCOUNT BE TURNED OVER TO A COLLECTION AGENCY OR ATTORNEY, YOU AGREE TO BE RESPONSIBLE FOR ALL COLLECTION COSTS OR ATTORNEY FEES INCURRED. IN CASE OF SUIT, YOU AGREE THE VENUE SHALL BE IN BROOME COUNTY COURT, NEW YORK. **WAIVER OF CONFIDENTIALITY:** IN ANY EXTERNAL COLLECTION ACTION REGARDING YOUR ACCOUNT, YOUR FILE MAY BECOME A MATTER OF PUBLIC RECORD.

**RETURNED CHECKS:** THERE IS A \$15.00 CHARGE FOR ALL RETURNED CHECKS.

**DENTAL INSURANCE:** INSURANCE POLICIES ARE CONTRACTS BETWEEN THE INSURANCE COMPANY AND YOU. IT IS THE POLICY OF OUR OFFICE TO MAKE FINANCIAL ARRANGEMENTS WITH YOU DIRECTLY, SINCE YOU ARE RESPONSIBLE FOR TREATMENT CHARGES. BENEFITS FROM YOUR INSURANCE COMPANY WILL GO DIRECTLY TO YOU. OUR OFFICE WILL PROVIDE YOU WITH A COMPLETED INSURANCE FORM. WE ASSURE NO RESPONSIBILITY FOR THE AMOUNT OF INSURANCE COVERAGE OR DELAY IN REIMBURSEMENTS.

**MEDICAID:** I DO NOT HAVE OR ANTICIPATE THE NEED FOR MEDICAID TO ASSIST ME IN THE PAYMENT OF CHARGES INCURRED AS A PATIENT.

**AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:** I AUTHORIZE VALLEY DENTAL PEDIATRICS TO RELEASE TO MY INSURANCE CARRIER SUCH INFORMATION AS MAY BE NECESSARY FOR THE COMPLETION OF MY TREATMENT CLAIMS AND ASSIGN TO VALLEY DENTAL PEDIATRICS BENEFITS FOR SUCH CLAIMS.

I HAVE READ AND UNDERSTAND THE ABOVE,

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(PATIENT OR LEGAL GUARDIAN SIGNATURE)

**PEDIATRIC DENTISTRY: GARY W. BIGSBY, DMD**