Drs. Tauber & Sciascia

Financial Agreement

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY A PHOTO I.D. AND INSURANCE CARDS FOR YOUR FILE.

- **APPOINTMENTS** – 24 hour notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $35 - $50 depending on length of appointment may then be added to your account.

- **CO-PAYMENTS** - By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, after 60 days an interest charge of 18% APR or 1.5% monthly may be added to your account.

- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. All patients will be responsible for their co-payments and deductibles. If we do not "participate" with your plan, we will send a courtesy insurance form to your carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to our office.

Private Insurance Authorization of Assignment of Benefits/Information Release: I, the undersigned, authorize payment of dental/medical benefits to Drs. Tauber & Sciascia's office for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of dental/medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS**-Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. If payment arrangements have been made, we require a credit card on file for monthly payments to be applied until balance is paid in full.

- **DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS**- The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Drs. Tauber & Sciascia's office will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Should it become necessary for us to use an attorney to collect payment from you, you will be additionally responsible for whatever charges incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS AND CARECREDIT.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name:_____ **Date of Birth:**_____

Responsible Party Signature:_____ **Date:**_____

Print Name:_____ **Relationship:**_____