FINANCIAL & INSURANCE:

We are happy to file insurance claims necessary to see that you receive the full benefits of your coverage; however, **we cannot guarantee any estimated coverage**. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges and pay the estimated portion that insurance will not cover. If your insurance company payment is not received within 60 days from the start of treatment, the entire balance is due from you and reimbursement can be obtained directly from your insurance company.

Verification of benefits is not a guarantee of coverage or payment. In addition, some services/visits may be medical in nature in which office DOES NOT participate in any medical plans and service or visit is patient responsibility in full. This includes office visits in conjunction with same day procedures! Office Visit fee is $ 100.00 in addition to same day procedures.

**************************************CHECKS ARE NOT ACCEPTED*******************************

Visa, Mastercard, Discover & American Express:

***************ACCOUNT HOLDER MUST BE PRESENT or Payment can be called in over the phone.************

CareCredit:

Per CareCredit Guidelines, account holder must be present. Over the phone payments are NOT accepted. Terms offered are:

6 mths same as cash for amounts less than $1000.00.
12 mths same as cash for amounts over $ 1000.00

( ) **HAVE MEDICAID** AND SIGNED WAIVER THAT SERVICES REQUIRE AUTHORIZATION OR THAT SOME SERVICES ARE NOT COVERED. Per Medicaid, any Private Insurance must be billed first. Please provide information if applicable. **Failure to provide private insurance is FRAUD.**

( ) **HAVE MEDICARE** & SIGNED WAIVER THAT DENTAL SERVICES ARE NON-COVERED

$ **50.00 NO-SHOW FEE** MAY BE APPLIED FOR FAILURE TO CANCEL OR RESCHEUDLE APPOINTMENTS WITHIN 24 HOURS

$ **25.00 FEE** FOR 3RD PARTY PAPERWORK EX: **EMPLOYER/FMLA FORMS**

REFUNDS: Overpayment on accounts that require a refund will be done ***after* 30 days**. Stop payment fee of $ 20.00 for lost checks if re-issued.

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to Lafond & Tambini, D.M.D., P.A. and am financially responsible for ALL non-covered services. I also authorize to Lafond & Tambini, D.M.D., PA. to release any information to my insurance company(s) in order to process claims.

If no insurance: I am responsible for all services on the date of treatment.

I have received notice of the offices privacy practices in regards to the protection of my health information.

Signature*____Date_____________________

Relationship to Patient (Please Circle): Father Mother Step-Parent Foster Parent Legal Guardian (Paperwork Provided)

This is also the responsible party on the account that accepts financial responsibility