

Dr. Harold J. Krinsky & Dr. Lawrence M. Bonanno

Financial Options:

1. Pre-payment (treatment over \$1000.00 only)

Payment at time of scheduling Appointment: 7% off with cash or check or 5% off with credit card * excluding Care Credit

2. Half & Half plan:

Half of the payment is due at the first treatment appointment & the remaining half is due at the final treatment appointment

3. Care Credit:

No interest up to 12 months or a low interest of 14.9% up to 60 months (application required)

4. Lending Club –Patient Solutions

True No-Interest Plans for 6 or 12 Months and Extended Plans with low monthly payments based on your credit

Senior Discount: At appointment 10% off with Cash or check or 7% Credit card payment * Excluding Care Credit

DENTAL INSURANCE BENEFITS: We gladly process your insurance claim as a courtesy and ESTIMATE the portion covered by your insurance. **Your insurance policy is a contract between you and your insurance carrier and as a provider we are not party to that agreement.** The quality of insurance policies varies greatly and therefore WE CAN ONLY ESTIMATE your covered benefits and cannot guarantee coverage. We ESTIMATE the amount that may NOT BECOVERED financially by your insurance. That amount is due at the time of treatment unless an option above has been agreed upon prior to your service.

** Please note that we allow 60 days for a dental claim to process. If payment is not received within 60 days of treatment, the outstanding balance is your responsibly.

Cancellation Policy:

Once a dental appointment has been made, please keep in mind that this time has been reserved especially for you. We require a full 48-hour notice for any appointment changes or cancellations. We reserve the right to charge **\$50.00 per hour for cancelled and failed appointments without notice .**

My signature below acknowledges that I have read the policy in its entirety. I also understand that payment of this account is my full responsibility, regardless of the amount my dental insurance benefits.

X _____

Patient / Parent / Guardian Signature

X _____

Date

Updated 2-24-16