Brilliant Smiles of Maryland
Alex Fishman D.D.S.
11710 Reisterstown Road, Suite 201
Reisterstown, MD 21136
(410) 833-8380

OFFICE FINANCIAL AND INSURANCE POLICY

In an effort to avoid misunderstandings and to keep the high cost of billing to a minimum (thereby being able to maintain the fees at a reasonable level), we are presenting you with a statement of our office policies concerning payment of your account and the processing of your insurance fauns.

This office is happy to cooperate with the patients who are covered by insurance. We only ask that you read your policy to be sure that you are fully aware of any limitations of the benefits provided.

It is important to understand that in most cases your insurance is designed to reduce your cost NOT to eliminate it completely. You are ultimately responsible for the full amount of you bill regardless of your insurance coverage. If your insurance company has not paid your claim within 60 days, the balance will automatically be billed to you and you will be responsible for the balance to be paid in a timely manner.

BROKEN APPOINTMENT POLICY

Please be advised that our office will be as flexible a possible to meet your needs in scheduling appointments. However, there will be a minimum of **$50 per half hour** charged to your account for broken appointments without **72-business hour notice**. Multiple failed appointments will result in discharge from our office. ~ **Initials** _____ ~

FINANCIAL ARRANGEMENTS

Payment is expected at the time of treatment. The office accepts Visa, MasterCard, Discover, American Express cash and checks. For patients undergoing extensive treatment, a financial plan can be arranged. Accounts are considered past due after 30 days. Past due accounts will be charged a Rebilling /Finance charge of $10.00 per month. Accounts past due 60 days will be turned over to R & R Professional Recovery for collection and will be subject to all collection fees, interest charges, attorney fees and court costs. Checks returned by your bank will be subject to a $35 fee. Immediate remittance, in the form of cash, money order, or certified funds, is expected.

Thank you.

I have read the above policy and agree to accept all financial responsibility.

_____ _____
Signature of Patient Date

I authorize the release of any information necessary to process my dental claims.

_____ _____
Signature of Patient Date