Marina Sokolina, DDS
Herbert Frankel, DMD
Inna Gellerman, DDS
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Relationship-based Integrated Care

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FINANCIAL POLICY FOR PARTICIPATING INSURANCE COMPANIES

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to initial treatment.

ALL PATIENTS MUST COMPLETE INFORMATION & INSURANCE FORM BEFORE SEEING THE DOCTOR.

YOUR COPAY IS DUE AT THE TIME OF SERVICE.

REGARDING INSURANCE

We will accept assignment of your insurance benefits at the time of your visit(s). However, we do require your co pay at the time of service. Also, you will be billed for any amount that your insurance states is not dentally necessary and/ or is not covered under your contract. Insurance is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible, coinsurance, or any other balance determined by your insurance company to be your responsibility.

ADULT AND MINOR PATIENTS

- Adult patients (18 or older) are responsible for payment.
- The adult accompanying a minor and the patient (or guardian of the minor) is responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless paid by cash, check or credit card at the time of service.
- In case of rescheduling or cancelling appointments, a min. of 24 hr is required to avoid a $75 fee.

PATIENT LIABILITY

If this account is assigned to an attorney for collection and/or suit, I shall pay 33 1/3% of the claim as payment for attorneys fees and costs of collection.

RETURN CHECK POLICY

For any check that is returned from the bank, there will be a service charge of $25.00 that must be paid to Dr. Maria Sokolina

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the financial policy. I understand and agree to the financial policy.

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE