CONFIDENTIAL

Steven M. Alper, DMD

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Financial Policy

Your clear understanding of our financial and office policies is important to our professional relationship. **Please read them carefully.**

- We strive to see patients at their scheduled appointment time. Therefore, if you are more than 15 minutes late, you may be required to reschedule your appointment, and you will be charged a fee of 30% (minimum $75) of the full appointment cost. For appointments over 60 minutes, a non-refundable deposit may be necessary to book an appointment.
- We require at least 48 hours' notice to cancel or change appointments. You will be charged a non-refundable fee of 30% (minimum $75) of the full appointment cost if you cancel or change your appointment less than 48 hours prior. We also reserve the right to dismiss patients from the practice if necessary.
- We bill most domestic insurance carriers if proper paperwork is provided to us. If we receive incorrect or outdated information from you and the claim is rejected, professional fees are due from you. We will provide you with an itemized receipt so that you may then bill your insurance company directly.
- If your insurance information changes during treatment, it is your responsibility to notify us immediately. If the information changes and the claim is rejected, professional fees are due from you.
- It is your responsibility to research and understand your specific insurance plan. If a particular service or diagnosis/ treatment is not covered by your insurance, you will be responsible for the fees associated.
- Your payment is due on the day of your procedure. As a courtesy, we bill insurance. If your account goes over 30 days, you are subject to a 1% interest charge per month. There is a $45 fee for all returned checks.
- Any fees incurred as a result of sending a delinquent account to collections will be the responsibility of the account holder.

I understand that I am responsible for all fees incurred at Dr. Steven M. Alper's office, regardless of insurance estimates or payments.

- **Payment Options** (please check):

☐ 1. Direct Insurance reimbursement: I choose to make full payment in the office and have my insurance directly reimburse me.

☐ 2. Estimated Co-payment: I choose to pay my estimated co-payment at the time of service. By entering my credit card number and signing below, I authorize Dr. Steven M. Alper, DMD PLLC to charge the credit card on file for any remaining charges on my account after insurance payments are credited. I am aware that I am responsible for all charges regardless of insurance coverage and that Dr. Steven M. Alper, DMD is not party to my insurance contract.

Credit Card Number: _____ Expiration Date: _____ CVV: _____

☐ 3. Uninsured: I do not have dental insurance and will make full payment at the time of service unless an alternate payment agreement is made.

I have reviewed and understand the above office policies.

Signature (Print/Sign): _____ Date: _____

*Please print forms and bring them to the office for your first appointment. **Please do not send sensitive material such as credit card numbers, social security numbers, Insurance ID numbers, etc via email.** Steven M. Alper, DMD PLLC is not responsible for any sensitive information that is sent in this manner.

Print Form