Penny Resnick-Graulich, D.M.D
Main Street Pediatric Dentistry
115 Main Street
Suite 302
Tuckahoe NY 10707

FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing your children with the most comprehensive dental care using only the highest quality materials and technology available in dentistry today. We are also committed to providing your children with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges that occur for your family are your responsibility regardless of your insurance coverage. We must emphasize that as your child's dental care provider, our relationship is with you not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will process all your insurance claims. You will direct your insurance company to pay benefits directly to our practice by signing the authorization on assignment of benefits agreement. In order for our practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance card.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the financial reconciliation of insurance payments. Our practice accepts cash, personal checks, Mastercard, Visa and American Express. Payment arrangements are available with prior request and approval from the office manager.

Returned checks will be charged the fees we incur from our bank.

Missed appointments or rescheduled appointments will be charged $50.00 after the 3rd no-show or cancel without 24 hour notice to change or reschedule your appointment.

Please don't hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing your child/children with the ultimate experience in dental care.

_____ _____

Print Name of Patient/Patients Date

_____ _____

Print Name of Responsible Party Signature of Responsible Party