

Stratford Dental Office Policy

Please note that our office does not participate in any managed care programs (i.e. PPO or DMO). If your insurance plan is a managed care plan and you have services provided by our office, your insurance company will pay less than they would pay to a participating dentist, or they may not pay any benefits at all.

If you choose, we will file your claims for you. You will be expected to pay any deductible and co-payment, as best as we can estimate, on the day services are provided. If there is a balance for services provided, after the insurance pays, you will be billed for the balance and be expected to pay the balance within 15 days. It must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

Your insurance should pay within 30 days. If payment is not received from the insurance company within 60 days, you must pay the balance due and seek reimbursement from your insurance company yourself.

If your insurance company makes any check payable to you and your account with us has a balance, you will sign the check and make it payable to Stratford Dental, P.C.

Since by taking your insurance on assignment, we have to wait for your payment, this courtesy may be withdrawn at any time.

Our office will not enter into a dispute with your insurance company over a claim. This is your responsibility; however, we will provide all necessary information to you and/or your insurance carrier.

If you understand and agree with all of the above, please sign your name and we will accept your insurance assignment.

Cancellations - We require at least 24 hours notice to change your appointment; otherwise, there will be a cancellation fee charged to your account.

Payment - Payment is expected when services are rendered, unless prior arrangements are made.

Finance Charge - A 1.5% monthly finance charge will be added to all overdue accounts.

Delinquency - If your account falls into delinquency you agree to pay any and all collection agency charges, attorney and court fees.

Print Name: _____

Signature: _____ Date: _____