



Dr. Drew S. Griffith

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Financial Policy

Importance of patient awareness regarding insurance benefits:

The office of Drew S. Griffith realizes how important insurance benefits are. We ask that you carefully review your policy and / or contract your insurance carrier provides you so you are aware of benefits, frequencies, limitations and / or restrictions. **Dental insurance is a contract between you and your insurance company. Our role is to assist you with filing your claims.** Your dentist is providing the highest quality care for you and your family regardless of insurance frequencies, limitations and / or restrictions. Please be aware that your insurance company may have a yearly maximum and anything over that amount will be your responsibility. If you have two insurance policies, please be aware of both policies – **not all secondary policies will cover remaining portions.** Your insurance company mails a copy of an Explanation of Benefits (EOB's) to you. Please pay attention to these statements. Check your policy for a deductible, and if your insurance pays at a percentage or by their allowed fee schedule. Please provide us with a copy of your insurance card at your first visit and benefit booklet (if available) or at the time dental coverage changes. **It is your responsibility to provide us with information on any future changes in your insurance.** If services have been provided with any other provider within the existing benefit year, please advise us.

_____ (initials) I understand this information.

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In order to provide you with the highest quality dental care on a sound business basis, we provide our patients with estimates of fees. The patient, the parent and / or the guardian is responsible for the patient portion on the date of service. This is not your insurance company's responsibility. **We will file all necessary claims to your insurance as a courtesy to you.** It is your responsibility to call your insurance company if they have not paid your claim within 30 days from the date of service. Any balance past 30 days is your responsibility, and interest will be applied to your account at the rate of 1.5% per month.

The financial options that we provide at this time: (check all that apply)

- _____ Cash or check on the date of service
- _____ 5% reduction on the patient portion of \$500.00 if paid on the date of service with **cash or check only**
- _____ Major credit card (American Express, Discover, MasterCard, Visa)
- _____ Extended payment plan (based on availability)

It is **your** responsibility to complete treatment and follow recommended maintenance schedule. If the treatment and maintenance plans are not followed and / or appointments are missed, adverse results could affect your dental health. If you do not proceed with your treatment in a timely manner, further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints can be affected. _____ (initials) I understand this information

Appointment Commitment

We appreciate your choosing our office for your dental needs. We take this responsibility seriously and have a qualified staff ready to accommodate you during your reserved appointment time.

Please review the following:

If circumstances occur and it is necessary to change your scheduled appointment, we request that you give us a least **24 hours notice**.

A broken appointment, on in which a patient does not call or show up, **is not acceptable**. If you have scheduled an appointment and do not show up or call, it may be necessary for you to come into the office personally to schedule any future appointments.

There may be a fee of **\$50.00** per missed appointment, per provider, per hour.

_____ (initials) I understand.

I understand and agree to the aforementioned, and I promise to pay any / all remaining balance on my account.

X _____ Date: _____
Signature of patient, parent or guardian