Larry Napolitano, DDS

Statement of Office Policy

Our goal is to provide dental health care that exceeds the standards of our peers. We will provide this care in the most courteous, cost effective, and conscientious atmosphere. It is important that you are involved in your care. That involvement starts with a clear understanding of office policy.

It is our policy to present planned treatment to all patients in advance of treatment. In the event of emergency treatment or alteration of planned treatment you will be informed of required care. We will provide an estimate of the cost of planned care. Please let us know if there are any questions concerning planned treatment or estimated fees. **It is our policy that payment for dental services is *due on the day services are rendered.***

INSURANCE PATIENTS: Our office will process insurance claims as a courtesy to you. You have the option of paying in full at time of treatment and having your insurance company reimburse you directly OR paying only the estimated co-pay and having your insurance pay us. All patient accounts will be secured with a credit card. Please note that if your insurance does not pay within sixty (60) days, we reserve the right to bill your credit card. Please be confident we will do all we can to assist in collecting on your behalf from your insurance.

Please check the insurance option you prefer:

___I will pay in full at time of treatment and have my insurance reimburse me directly.

OR

___I will pay the estimated patient portion not expected to be paid by my insurance prior to my scheduled appointment. If my insurance denies payment/benefits or does not pay within sixty (60) days, I authorize Dr. Larry Napolitano to charge my credit card.

MC __ Visa __ # _____ exp. Date _____ signed _____

APPOINTMENT CANCELLATION: There will be a minimum $50.00 cancellation fee charged to the above authorized credit card for appointments missed on the hygiene schedule and a $100.00 per every ½ hour of appointed time on the Doctor's schedule for cancelled, rescheduled or missed appointments with less than 48 hours notice.

RETURNED CHECKS: There will be a $25.00 processing fee for a returned check. The amount of the returned check and the processing fee will be charged to the above authorized credit card.

I understand these policies. I understand that I am responsible for all charges regardless of insurance coverage.

Signed (patient or guardian)_____ date _____