

**Dr. A. Noorani**  
**Important Information and Financial Policy**

We welcome and value you as part of our dental practice. In order to avoid confusion regarding our financial and insurance policies, please review this document and sign it. We accept cash, check, VISA, MasterCard, American Express, Discover and CareCredit. If you have any questions, please speak with our front desk staff.

Today's dental plans are designed to *assist* patients with dental treatment. It is important to remember that *necessary* services are not *necessarily* covered. Our goal as your dental care provider is to make sure you have healthy teeth long after you change dental plans. It is your employer who chooses your benefits and how they are paid.

Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. Your estimated patient portion must be paid at the time of service. As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance, paid-in-full. If you have any questions, our courteous staff is always available to answer them.

*Please place your initials by the scenario that describes your financial/insurance situation:*

\_\_\_ I realize Dr. A. Noorani is not a participating provider for my company and he will be waiting for the assignment of benefits as a courtesy to me. I understand I am responsible for my account regardless of my insurance status. I also understand that my insurance is an agreement between the insurance company and me, therefore if the practice does not receive payment from my company in 90 days, the insurance balance for my account will be transferred to me personally.

\_\_\_ I realize that Dr. A. Noorani is a participating provider for my dental plan and I am required to pay my estimated portion of the dental fee at each visit for the treatment I had that day. The amount I will be required to pay will be explained to me prior to my appointment. I understand that dentistry is not an exact science so my treatment may need to be altered at the time of the appointment but I will still need to pay my portion of the visit if different from the original estimate.

\_\_\_ I do not have dental insurance. I am responsible to pay my bill in full at each visit. The practice's personnel will give me information on outside financing if I request it.

I must respect the practice's personnel's schedule and will give 24 hours notice if I need to change my appointment time, otherwise I may be charged anywhere between \$25.00 to \$75.00, depending upon the work scheduled. All major dental treatment must be paid in full prior to being inserted in your mouth. If I have insurance that the practice accepts, I must pay my portion in full as estimated by the office.

**In order to keep our dental fees in line, our practice does not bill our patients; so after the first courtesy billing, a \$10 billing charge will be added to my account each month that I have an outstanding balance.**

I give permission for my dentist or his associate and clinical team to take any necessary radiographs, study models and photographs to make a complete diagnosis of my dental needs. I also give permission to use this information for educational purposes in-office.

*If you have minor children in our practice, please read and initial below:*

\_\_\_ I give my permission to treat my minor child/children in my absence, whether I drop them off for treatment or another adult brings them to the doctor for treatment. I will give my child a check or credit card information to fulfill the amount due for their treatment.

*If you have an adult child (over 18) and are still financially responsible for their treatment, please read, fill in the child's name and initial below:*

\_\_\_ I will continue to be financially responsible for \_\_\_\_\_ (child's name). If I have insurance, I will provide the insurance company with the necessary documentation that they are a full-time student.

**I have read, understood and agree to the statements listed above. I have received a copy of this document for my records.**

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