SHORELINE PERIODONTICS PC
Committed to Excellence in Periodontics and Dental Implants

Gregory A. Toback, D.M.D., M.S.
Board Certified Periodontist

OFFICE POLICIES AND FINANCIAL AGREEMENT

Thank you for putting your trust in Shoreline Periodontics, PC. Your oral health is our primary concern, and we are committed to providing our patients the best care possible in a comfortable and caring environment.

Our financial policy does require payment in full at the time services are provided. We do accept assignment of benefits for most major insurance policies. Please understand that your account must be kept current throughout treatment. The following is a statement of our Financial Policy which we require you to read, agree to, and sign before any treatment.

All new patients must complete both sides of our "New Patient Registration" form before seeing the doctor.

PAYMENT OPTIONS

*Cash/Check
*Visa, MasterCard, American Express, and Discover Cards
*CareCredit® and Springstone Patient Financing

Payment plans are available up to 12 months with no interest on charges over $300. Extended payment plans beyond 12 months are also available. We will be happy to provide you with their information if you would like to apply for a line of credit.

INSURANCE

If your plan provides benefits for services in our office, you will be asked to leave the anticipated co-pay at each visit. **THIS IS ONLY AN ESTIMATE.** We will file insurance claims and submit the information necessary for your insurance company to process those claims. This is a service we provide as a courtesy to our patients, but please understand you have the contract with the insurance company and ultimately are responsible for payment. We will not guarantee a payment will be made from your insurance company, nor will we make a settlement on a disputed claim.

Our practice is committed to providing the best treatment possible to our patients. You are responsible for the cost of treatment provided regardless of an insurance company's arbitrary determination of the "allowable" fees.

Remember, you are the holder of the contract. It is your responsibility to ensure you understand the contract between you and your insurance company and to know the benefits available under your policy. If after 60 days your insurance company has not rendered payment the balance will become your responsibility.

****Our insurance coordinators are available to assist you in understanding your benefits and filing the necessary paperwork****

PAST DUE ACCOUNTS

Accounts without acceptable payment activity for 60 days will be considered past due. A billing charge may be added to your account in addition to the original account balance.

COLLECTIONS

Accounts without acceptable payment activity for 90 days will incur a collections fee of 15% in addition to your current balance. If this becomes necessary, your account will be placed with an outside collection agency and you will not receive any further account notifications from our office.

CANCELLATIONS

If you have scheduled an appointment with the Doctor or Hygienist and need to cancel or reschedule, a minimum of 24 hours notice is required. If you fail to provide adequate notice, we reserve the right to bill you $50 for the appointment you had reserved.

MINORS

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will not be performed, unless prior payment has been made or charges have been authorized by the parent or legal guardian to a valid credit card accepted by our office.

PHOTOGRAPHS

I give my permission to Dr. Gregory A. Toback or any representative he may designate, to photograph me for diagnostic purpose and to enhance the medical record. I agree that these photographs will remain Dr. Toback's property (this includes all diagnostic x-rays). I further authorize Dr. Toback to use these photographs for teaching purposes, to illustrate scientific papers, for use in lectures. If any photographs are used for any reason I shall not be identified by name.

SIGNATURE RELEASE

I authorize the releases of dental/medical information necessary to either process my insurance claims for treatment performed by Shoreline Periodontics, PC, or when necessary, to other providers rendering medical/ dental care. I assign all dental/ medical/ surgical benefits for treatment performed by Shoreline Periodontics to which I am entitled to be paid to Shoreline Periodontics, PC. This assignment will remain in effect until revoked by me **in writing**. A copy of this assignment is to be considered as valid as the original.

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PATIENT'S SIGNATURE (Parent if Minor) DATE

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PATIENT'S NAME (Please Print)

****All patients are required to sign an updated financial agreement every year****