*Northampton Family & Cosmetic Dentistry*
**www.EnjoyYourSmile.com**

## Financial Review and Information

**Please read - ask questions as needed:**

This is an agreement between Dr. Teddi Olszewski and Olszewski Dental Associates, DMD, LLC, a Massachusetts Professional Corporation, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited the words "we," "us," and "our" refer to Dr. Teddi Olszewski and Olszewski Dental Associates, DMD, LLC.

By executing this agreement, you are agreeing to pay for all services that are received.

**Monthly Statement:** If you have a balance on your account based on a financial agreement with the office, we will send you a monthly statement. It will show any prior balances and new charges as well as payments or credits applied to your account during the month.

**Payments:** Unless we approve other arrangements in writing, the current balance is due and payable at the time of treatment; a balance will be considered past due if not paid by the end of the month.

**Charges to Account:** If arrangements are made in advance of treatment we will allow charges to be placed on your account (BASIX students may not qualify). We shall have the right to cancel this privilege at any time; future visits would then need to be paid at the time of service.

**Payment Options:**

A. You may choose to pay by cash, check, credit card or debit at the time treatment is rendered.
B. On treatment involving laboratory fees (crowns, bridges, dentures, etc) you may choose to pay 50% on the preparation date and the balance at the time of the insert (BASIX students may not qualify).
C. On extensive treatment, you may prefer to secure a bank, credit union, or third-party financing for the entire amount and make payments to the lending institution.
D. We offer special financing through CareCredit. They allow monthly payment plans and 0% interest/ deferred interest promotions.
E. All financial arrangements and insurance questions can be discussed in advance of treatment - we will be happy to go over all your payment options with you.

**Insurance:** Insurance is a contract between you and your insurance company. We are *NOT* a party to this contract. Since we are independent, our fees are separate from your plan's contracted fee allowances which means you may receive higher reimbursement/coverage by seeing a contracted office. If you choose to see us, a non-contracted dentist, you agree to pay for treatment in full and at the end of each appointment we will submit a claim to your insurance company for your direct reimbursement (the insurance

company makes the final determination of your eligibility and amount of payment). We do NOT process claims for Medicare; you need to request reimbursement thru Medicare form 1490S.

**Discounts:** Patients 65 or older are eligible for a 5-10% "senior" discount.
College students are eligible for a 5% discount (5 area colleges only) unless participant of BASIX Savings Program; a *current* student ID card is required.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce/separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**Past due accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees that we incur plus all court costs. In case of suit, you agree the venue shall be in Hampshire County, MA.

**Returned checks:** There is a fee (currently $25.00) for any checks returned by the bank.

**Appointment Cancellations:** In order to accommodate our patients with their pre-booked appointments, please call with 48hrs business days' cancellation notice if it is absolutely necessary to rearrange your schedule. If less notice is provided, a rescheduling deposit may be required. Thank you in advance for your understanding and courtesy!

**Waiver of confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**Transferring of Records:** You will need to request in writing by signing a record release form if you want to have copies of your records sent to yourself, another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

**Co-signature:** If another person signs this or another financial policy, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

**Your dental health is *very* important to us. We are here to help you afford your dental treatment. When the type of treatment has been decided upon, time will be appointed for completion of the case. Financial arrangements are customarily made at this appointment.**

Patient's Name: _____

Responsible Party: _____
*(if the patient is not of legal age and/or patient has a legal guardian)*

Signature: _____

Date: _____