**Lori M. Nasif D.M.D.**
**Family, Cosmetic, and Implant Dentistry**
**810 Abbott Blvd Suite 203 Fort Lee, NJ 07024**
**201-224-6430 /email : drnasif@fortleedentist.com**

# PATIENT FINANCIAL POLICY

**Patients with Dental Insurance :** As a courtesy, we will process your dental insurance claims on your behalf, however, **you are responsible for any co-insurance, co-payment, and deductibles that are not paid for by your insurance** at the time services are rendered.

**Patients without Dental Insurance**: If you do not have dental insurance, you are responsible for your payment when services are rendered unless other financial arrangements have been made.

**Financial Payment Options:** We accept cash, major credit cards including AMEX, Mastercard, Visa, and CareCredit.

We offer **CARECREDIT** for short and long term financial payment options. CARECREDIT, a third party lending institution, offers 6 and 12 month interest free payment options or longer payment plan options of up to 60 month with interest.

**Cancellation Fee Policy**- If you are unable to make your appointment, we require **48hrs notice**, otherwise, a **cancellation fee of $50.00** will be incurred.

I have read and understand the policies regarding insurance and payment for services. I agree to pay at the time of service the portion not covered by my dental insurance. I understand that this is not a guarantee of what my insurance will pay, and that should insurance pay less than the estimate, I will be responsible for payment of the balance. In addition, should the insurance delay payment for any reason, I will be responsible for the entire account balance including finance charges after 90 days.

Patient Signature (Parent or Guardian if under 18) X _____

Date X_____

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# PATIENT FINANCIAL INSURANCE POLICY

**Patient Name**_____ **Date**_____

**Please initial the following :**

I understand all treatment plans are only an estimate and may differ from actual payments. I am responsible for the difference.____

I understand that no financial arrangements will be made after work has been initiated.____

I understand that if any work I have done is denied by my insurance company I am responsible for the balance_____

I understand that 50% of my copayment is due on the start of major restorative work and the remainder is due on the insertion. Any balance left after insurance pays will be my responsibility and all work must be paid in full on the day of delivery.___

I have read and understand the policies regarding insurance and payment for services. I agree to pay at the time of service the portion not covered by my dental insurance. I understand that this is not a guarantee of what my insurance will pay, and that should insurance pay less than the estimate, I will be responsible for payment of the balance. In addition, should the insurance delay payment for any reason, I will be responsible for the entire account balance including finance charges after 90 days.

Patient Signature (Parent or Guardian if under 18) X _____

Date X_____