FIRST MOUNTAIN DENTAL GROUP
KONSTANTINE TRICHAS, DDS

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FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges that you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process your insurance claims. You may direct your insurance company to pay benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, a completed dental insurance form or proof of insurance for your current carrier must be provided.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Outside financing is available through Care Credit, subject to approval.

Please note that our office reserves the right to charge you for broken appointments and appointments cancelled without 48-hour advance notice.

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

In the event that my account becomes delinquent for more than 60 days, I agree to pay all reasonable collection costs, court costs, and/or attorney fees, not to exceed 50% of the balance, as well as any interest on fees accrued with the collection of my account.

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Patient Name **Name of Person Completing Form (Responsible Party)**

_____ _____

Signature of Patient/Responsible Party **Date**

Rev 1.1.12