Financial Agreement

EDWARD SLOYER, DDS
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Smile Designs
OF LONG ISLAND

Patient's Name
Last First Middle

Social Security Number: Date of Birth:

Who is responsible for paying this account?
☐ Self -or- ☐ Name_____ Relationship to patient if other than self _____

Insurance Information

Does patient have dental insurance? ☐ Yes ☐ No (If no, then skip this section)

Primary Dental Insurance Company (A):		Secondary Dental Insurance Company (B):	
Group Number	Policy Number	Group Number	Policy Number
Name of Policy Holder		Name of Policy Holder	
Social Security Number	Date of Birth	Social Security Number	Date of Birth

Names of other family members covered by primary (A) and/or secondary (B) insurances:

	A	B		A	B
(1) _____	☐	☐	(4) _____	☐	☐
(2) _____	☐	☐	(5) _____	☐	☐
(3) _____	☐	☐	(6) _____	☐	☐

We participate in many, but not all insurance plans. As a participating dentist, our office bills insurance companies directly for covered services. However, patients are required to pay their deductibles, co-payments, and non-covered procedures at the time of service. Most dental plans have an annual dollar maximum that they will pay toward the cost of a member's dental care within a specific benefit period (usually January through December). This includes dental care received at this and/or other dental offices (including specialists). The patient is personally responsible for paying costs above the annual maximum. As a service to our patients, this office will attempt to aid in determining the plan's paying guidelines and in estimating treatment costs, but ultimately the patient is responsible for understanding his/her specific contract with the insurance company. This office will recommend treatment based on the quality of care for patients, not the standard set by any insurance company.

Patients who are members of plans in which we DO NOT participate, are responsible for all fees at the time of service. Visits to this office are by appointment only. Please advise us at least 24 hours in advance if you are unable to keep your appointment. A fee for broken appointment(s) may be charged. Our office reserves the right to assess a service charge of 1.5% per month (18% per annum) on the patient's personal unpaid balance that exceeds 60 days, unless previous arrangements have been made.

I certify that I have read and understand the above and that the information given on this form is accurate.

Signature _____ Date: _____

Notice of Privacy Policies

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Signature _____ Date: _____