

Patient Name: _____

Advanced Dental Care of Englewood
Adrijana Miksa, D.M.D.
177 North Dean Street, suite 206
Englewood, NJ 07631
201- 227-DENT (3368)
201-227-3371 (fax)

**Patient S.S #: _____

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.
Payment
Payment in full is due at the time of service unless prior financial arrangements are made. We offer several payment options: Cash, Checks, Visa, MasterCard, Discover and American Express Monthly payment plans in accordance with the office credit guidelines
Insurance
Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will be happy to manage all claim submission and follow up on your behalf. After your treatment services have been submitted, please allow up to 30 days to receive your direct reimbursement from your insurance company. If you have any questions, our courteous staff is always available to answer them.
Prosthetics Any prosthetic work (i.e. crowns, dentures) WILL be payed for regardless of the patients' ability to schedule an appointment. We will hold your prosthetics and make sure you receive the highest quality of work for as long as needed, but it is the patients' responsibility to come to complete the work. Patient will be liable for their portion of insurance copay or full amount PRIOR to treatment.
Financial Consent The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.
I understand and agree to this Financial Policy and Agreement
**Signature of patient/responsible party Date