Closurdo
family dentistry

Patient Agreement

We would like to take this opportunity to welcome you to Closurdo Family Dentistry. The following is an agreement between our office and the patient or individual taking responsibility for payment, if someone other than Patient. In this agreement, the words "you", "your", and "yours" mean the Patient or individual taking responsibility for payment, if someone other than the patient. The word "account" means the account that has been established in your name to which charges are made and payments are credited. By executing this agreement, you are agreeing to pay for all services that are received.

Insurance

Insurance coverage is controlled by the contract between you and your insurance company. Our office is not a party to this insurance agreement, in most cases. We will bill your primary and secondary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and insurance benefits. We cannot guarantee benefits. You agree to pay any portion of the charges not covered by insurance. While our office will do our best to help answer your insurance questions, it is the account holder's responsibility to understand the coverage and benefits of the patient's dental plan.

Payments

Unless other arrangements are approved in writing, payment is due when the services are rendered. We accept cash, check, Visa, MasterCard, and Discover for your payment convenience you may apply for a payment plan through Care Credit or Citi Health which must be arranged and approved before work begins.

Lab related services such as crown and bridge, partial and full dentures require 50% down at the preparation date and 50% on the date of completion. If you have insurance benefits on these services, you must pay half of your portion at the start date and the remaining half when the service is completed.

Past due accounts

If your account becomes past due, we will take necessary steps to collect this debt. A 4% APR finance charge is automatically tabulated onto accounts 60 days or older. If we do have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. Our office reserves the right to refuse to see any patient with a past due balance or with an account under collection status. In addition, a patient may be discharged from the practice if their account is referred to a collection agency and will have to contact the collection agency for any payment related issues or concerns.

Uncompleted services

In most cases, any multi-visit service not finished within a 60-day period and/or within the time limit recommended, the case may be closed and we will submit a claim for the uncompleted service to the insurance company for the covered service and/or the account holder is responsible for any remaining payment portion or determined by the work performed and any related expenses. An additional charge may apply if we retreat or redo a multi-visit service or any service related to the uncompleted multi-visit service or uncompleted treatment plan.

Missed appointments

Our office policy requires at least 24 hour notification. A charge of $35 per missed appointment may occur for patients who cancel or miss their appointment without 24 hour notice. These charges will be the account holder's responsibility and billed directly to the account holder. This charge will be due within 30 days and/or before the patients next visit. Our office reserves the right to discharge a patient from this practice if there is an account history of missed or cancelled appointments within 24-hours of their appointment. It is the account holder's responsibility to remember the patient's appointment, although our office will strive to provide a courtesy reminder for the patient.

Transferring records

You will need to request in writing to have copies of your record sent to another dentist or organization, or for a copy to be made for your own records.

Prescriptions

In most cases, a patient will need to be seen by a dentist in regards to a prescription request or refill. Our office reserves the right to refuse to see any patient seeking only medication instead of treatment and the right to deny a patient request or refill for a prescription.

Agreement

Your signature below, or that of the responsible party, on this agreement indicates you agree to all of the terms and conditions contained in this agreement. The agreement is effective as of the date signed and dated below. You may request a copy of this signed agreement for your own records.

Patient's name _____

Patient's signature _____

-or-

Responsible party's signature _____

Date _____

For staff use:

Witness signature _____

Date _____