2210 E. Henrietta Rd.
Rochester, N.Y. 14623
Telephone: (716) 424 -3310

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

1. Payment is due at time of service. We accept cash, money orders, checks, and Visa/Mastercard's.

2. All appointments are expected to be kept. Should you need to cancel any appointment, we require a 48-hour notice to do so. Any broken appointment will accrue a $50 broken appointment fee.

3. With assigned claims, we like to give the insurance thirty (30) days to make payments before we bill you. We CANNOT be responsible for any dispute over payment by the insurance company as the insurance contract is between you and the insurance company. However, we will help with the insurance claim in any way we can.

4. We may charge a service charge of 18% annually (1.5% per month), or a $3.00 minimum charge per month, on any principal balance remaining 30 days after the day of service, or immediately if a payment is late, for any reason.

5. Any payments that are sixty (60) days overdue, or thirty (30) days overdue more than once may be turned over to our collection agency and/or attorney and will be reported to TRW National Credit Reporting Service. You would be responsible for any collection or legal costs incurred in these cases. It is advisable that you contact us if you expect a payment delay or a problem before the payment is overdue.

6. In cases of divorce, separation, or legal responsibility, the patient, if of legal age, and/or the parent or guardian accompanying the patient will be ultimately responsible to our office, unless written permission is obtained before treatment from the person accepting financial responsibility.

7. If a check is returned by the bank, immediate payment by cash, money order, or credit card is expected, and the account will be charged a $35.00 service charge.

Thank you for understanding our Financial Policy. Please let us know if you have any questions.

I HAVE READ EACH OF THE ABOVE PARAGRAPHS AND UNDERSTAND THE FINANCIAL POLICY OF THIS OFFICE

____ Date ______________

Signature of Patient or Responsible Party