NY Periodontal and
Oral Implantology Associates

Peter A. Rosenstein, DMD

INSURANCE FINANCIAL POLICY

In our effort to provide the best possible care to you, our financial policy is designed to clearly define your responsibility for payment and our role with assisting you with insurance reimbursement for services you receive. **We participate with PPO Plans only, Guardian, Liberty Dental, MVP (excludes UVM), Delta Dental (excludes 32BJ), First Ameritas, Principal, Dental Select, Physicians Mutual, Cigna, and Security Life insurances. We also accept cash, checks, or credit cards.** If you have any questions about our participation, please contact your insurance company or call our office. If we do not have a contractual agreement with your insurance company, payment for office services is due at the time of service. We will submit your out of network claim to your insurance company so you can utilize your out of network benefits. We accept cash, check and all major credit cards.

We will gladly discuss proposed treatment and answer any questions relating to your insurance. You must realize, however, that --

1. Our fees are generally considered to fall within the acceptable range by most companies, and therefore, are covered up to the maximum allowances determined by each carrier. This statement does not apply to companies who reimburse on an arbitrary "schedule" of fees, which bares no relationship to the current standard and cost of care in this area.

2. If your insurance carrier requires a co-pay for specialist office visits, your co-pay will be collected prior to services rendered. If you have not met your annual deductible, a portion may be collected at the time of service.

3. You are responsible for informing us of any changes to your insurance plan or policy. Failure to do so may result in denial of coverage, the fees for which you will be responsible for.

We will do our best in the filing of insurance claims; however, all charges are ultimately your responsibility. Thank you for your understanding of our Financial Policy. If you have any questions, please do not hesitate to ask.

I understand and agree to the Financial Policy of Peter A. Rosenstein, DMD.

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Signature of Patient (or Guardian if minor) Date

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Print Name of Patient