DENTAL ASSOCIATES OF SHELTON LLP
190 CORAM AVENUE
SHELTON, CT 06484
PHONE (203) 924-4115
FAX (203) 924-1301

Financial and General Office Policy

The dentists and staff at our office are committed to providing you with the best possible care. As part of this commitment, we are available to discuss our professional fees with you during regular office hours. We feel that a clear understanding about our financial policy is most important in our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

1. Patients must complete the "Patient Information Form" and "Medical History" prior to seeing the dentists and/or hygienist.
2. Full payment for your office visit is due at time of service unless other arrangements have been made.
3. We accept cash, checks, Mastercard, Visa, Discover and American Express.
4. We require 24 hours notice for appointment cancellations.
5. Any patient who repeatedly fails his/her appointments will be required to make special payment arrangements for scheduled appointments.

Unaccompanied Minors

The parents or guardian are responsible for full payment. Non-emergency treatment will not be performed unless charges have been pre-authorized or a credit plan approved.

Insurance

If you have insurance, it is our policy to help you receive maximum benefits. However, insurance is a contract between you and your insurance company. We file insurance claims as a courtesy to our patients. It is the responsibility of the patient to be familiar with his/her insurance plan. This includes yearly maximums for cleanings and/or other dental work, covered and non covered procedures, and co-pays on such procedures. This information can be attained by contacting your insurance company or human resources at work. We will not be become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, or "Usual and Customary" fees other than to supply accurate and factual information as necessary. You, the patient, are responsible for payment of any balances to your account.

Signature.....

Printed Name.....

Date.....