Financial & Appointment Policy

Karyn M. Halpern DMD, MS

12 Roosevelt Avenue, Port Jefferson Station, NY 11776
P:631.928.1300
F:631-928-0616
www.portjeffersonsmiles.com

Financial Arrangement Clause:

At Port Jefferson Smiles, we aim to provide you with the highest quality dental care while ensuring transparency and clarity in our financial policies. Please carefully review the following information regarding payment procedures and insurance coverage:

1. Payment Expectations:

Due to the specialized nature of dental treatment and the resources invested in your care, payment is expected in full at the time of service, unless prior arrangements have been made in writing. [Initial here: _______]

2. Insurance Verification and Estimation:

If you have dental insurance and we are a participating provider, we will diligently verify your benefits and estimate your portion of the payment at the time of service. Please note that this estimation is based on the information provided by your insurance company and may not be entirely accurate. After your insurance company processes their portion, we will notify you of any outstanding balance. [Initial here: _______]

3. Out-of-Network Provider Policy:

If Port Jefferson Smiles is an out-of-network provider with your dental insurance carrier, payment for all services rendered will be due at the time of treatment. As a courtesy, we will submit the claim to your insurance company on your behalf, requesting reimbursement for any eligible benefits directly to you. [Initial here: _______]

Signature: ____________________
Date: ______________________

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4. Responsibility for Understanding Insurance Benefits:

We encourage all patients to familiarize themselves with their insurance policy and understand their plan benefits. Please be aware that your insurance policy constitutes a contract between you and your insurance carrier, and it is your responsibility to be informed about your coverage. [Initial here: _______]

5. Collection Policy:

If your insurance carrier does not remit payment within forty-five days, as permitted by law, any outstanding balance will become your responsibility. Additionally, accounts that remain overdue for more than 90 days will be referred to our collection agency, incurring an additional collection fee of $100. [Initial here: _______]

6. Appointment Policy:

Should you need to change a scheduled appointment, we require being informed at least two business days in advance. If your appointment is for two hours or more, we require as least four business days' notice. We reserve the right to charge your account a missed appointment fee of $75 hour for appointments that are not cancelled with sufficient notice. [Initial here: _______]

6. Agreement:

I understand the financial arrangements described. I understand that I am responsible for my total dental costs regardless of any insurance coverage. [Initial here: _______]

We appreciate your understanding and cooperation with our financial policies. Should you have any questions or require further clarification, please do not hesitate to contact our office.

Signature: ____________________
Date: ______________________