Jeffrey M Collura, DMD
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Turners Falls, Ma 01376

Financial Policy

Thank you for selecting us as your personal dental care team. To promote a long-term, mutually satisfying relationship, we would like to explain our office policy regarding treatment, insurance, appointments and fees. Please read this carefully and ask any questions or bring up concerns before treatment is rendered.

Treatment:
We will always recommend treatment base on optimal care, and not on insurances benefits. Insurance companies exist only to make money and do not always have your best interest in mind. We will however, always offer alternate treatment options that may better fit your health care budget.

Insurance:
As a courtesy to you, we will submit all insurance claims on your behalf, and any follow-up processes that may be necessary. Our staff prides itself on helping our patients maximize their benefits, and is always available for questions. Ultimately the patient is fully responsible for the charges for the treatment rendered. **Your insurance may not cover** the services or may only **partially** cover them and any **estimate** given by this office is considered a guideline until insurance payment is received and the patient's account is reconciled. The office makes **no guarantee** of the actual payment by your insurance company. At no time will we change treatment codes or dates of service to manipulate your insurance benefits. This is insurance fraud.

Missed Appointments:
When we schedule your appointment, this time is reserved exclusively for you. When you fail to notify us of your inability to keep the appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us **24** hours' notice when you realize you cannot keep an appointment. A **fee of $50.00** per hour scheduled may be charged for broken day of appointments.

Payment at time of service:
We accept cash, personal checks, MasterCard, Visa, Discover, and ATM cards. In addition, we offer Care Credit for those requiring extended payment plans. We will collect any deductible or estimated co-pay at time of service.

Returned Checks:
Will result in a **$35 fee** charged to your account. Cash or credit card must be used to pay remaining bill.

I understand that I am responsible for all fees incurred for dental treatment and agree to pay according to the option I have chosen. **Any account balance over 60 days will incur a 1.5% finance charge. Additional charges may occur if the account is turned over for collection.**

Signature:_____ Date:_____
(Patient/Parent/Legal Guardian)