



*****IMPORTANT PLEASE READ*****

Dr. Melissa Pecoraro

OFFICE POLICY

In order to accommodate the needs and requests of our patients, we are enrolled in many insurance plans.

While we are pleased to be able to provide this service to you, it is very difficult for us to be aware of all the individual requirements of each plan. Each plan has different rules regarding how often services may be performed.

Even within the same insurance company, the plans differ depending on the type of contract your employer has signed up for and negotiated with the insurance company.

If your insurance plan requires an authorized (referral) from your regular Dentist, it is your responsibility to get it and give it to the “front desk person” at our office at the time of your appointment.

If you are examined by the Doctor and we find out that YOUR REFERRAL IS NOT VALID, you will be responsible for the payment for that visit.

If we do treatment prior to pre-approval, and insurance does not pay, it is the patient’s responsibility.

As we are a specialty office you have been referred to, we do not always know your remaining maximums of your insurance plan; if you have gone over your yearly maximum, we will have to bill you for the balance the insurance does not cover. Predeterminations are not a guarantee of payment, just an estimate.

If your insurance requires a co-payment, THIS PAYMENT IS DUE AT THE TIME OF YOUR APPOINTMENT. Co-payments are a requirement of your participation with the insurance company. We accept checks, cash, Visa, MasterCard and Discover. Unless a previous financial agreement has been made with the Doctor, **any unpaid balance of more than 30 days, will incur a charge of 1% interest per month, plus the cost of collection charges if necessary.**

We require 48 hours notice for cancellation of either a cleaning or surgery appointment, otherwise you will be billed a MISSED appointment fee. The fee is \$50.00 for a missed recall appointment, \$75.00 for a missed scaling appointment, and \$200.00 for a missed surgical appointment. After two consecutive missed appointments it will be assumed you do not wish to continue treatment and your case will be forwarded back to your general dentist. If you do not have a dentist, we will handle any emergency you may have for up to 30 days past your last scheduled appointment.

With your cooperation and help, you should be able to receive all of the benefits offered to you, as well as our office being able to concentrate on caring for your periodontal needs.

I have read and understand the office policy and I agree to accept responsibility for payment in full for all “non-covered” services as needed, co-payments and non-referral visits.

Signature _____ Date _____

Witness _____ Date _____