



# CENTRAL NEW YORK ORTHODONTICS

## FINANCIAL POLICY

It is our goal for our patients and their families to understand their treatment needs as well as their financial responsibility before treatment begins. It is our goal to make dental treatments affordable for all of our patients. In an effort to avoid any future misunderstandings once treatment has started please review our office policies before starting treatment.

### PAYMENT POLICY:

1. Our initial consultation is complimentary. The consult includes diagnostic x-rays and photographs as needed to develop a treatment plan.
1. Central New York Orthodontics offers in house financing. Payments are spread out for a pre-determined time and may continue after active treatment has ended.
2. Financing is also available through Care Credit with prior approval.
3. Monthly payments are in the form of direct withdrawal from a checking account on the 10<sup>th</sup> or 20<sup>th</sup> of the month.
4. For payment in full and down payments we also accept personal checks, money orders, Debit cards, Visa, MasterCard, Discover, Amex and Care Credit.
5. Fees will apply for any check that is returned by the bank.
6. **MINOR PATIENTS:** In the case of divorced or separated parents that are utilizing our payment plan, it is THE CUSTODIAL PARENTS responsibility to make and follow through with payments according to the office contract.
7. **Additional Fees:**
  - a. A patient's non-compliance can affect the established treatment plan and estimated treatment time. If this occurs a patient consult or parent conference will be scheduled to discuss continuing treatment and additional fees.
  - a. Lost or broken appliances including but not limited to Invisalign trays and retainers will incur a replacement fee.

**ORTHODONTIC DENTAL INSURANCE:** Central New York Orthodontics will submit your Orthodontic claim for processing provided you agree to the following:

You must provide us with a copy of your dental insurance card and all of the information necessary to file your claim and verify your coverage.

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
1. Orthodontic insurance is generally a portion or a percentage of the treatment fee. You are responsible to pay our fees; not what your insurance company allows or considers "usual, customary and reasonable" (UCR) all of which vary one company to another.
2. If you have an orthodontic benefit you will be provided an outline at the start of treatment. Although we may estimate your insurance benefit, we are not responsible for YOUR insurance company's accuracy. Knowledge of your benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
3. Please understand that our responsibility is to provide you with treatment that best meets your needs, not to try to match your care to insurance plan limitations. *One example of this would be we will not keep you / your child in treatment longer than necessary so that you can receive your entire benefit.*

**BROKEN OR MISSED APPOINTMENTS:** To reschedule or cancel an appointment, you must give us at least 24-hour business day notice. If you arrive more than 10 minutes late (without notice) we may ask you to reschedule your appointment. Missed or late appointments prevent others from receiving the dental care they deserve. Multiple missed or late appointments can result in a fee. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept. While every effort is made to accommodate our patients preferred schedules some appointments are longer and need to be scheduled at certain times of the day.

I have read and understand this document in its entirety outlining the financial policy for Central New York Orthodontics.

\*Signature of Financially responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Adult patients are financially responsible for their treatment.**

