DR. TERESE N. FAY, DMD, PLLC
MANHATTAN DENTISTRY

20 East 46th Street, Suite 1003, New York, NY 10017
212.759.1383

OFFICE POLICIES and FINANCIAL AGREEMENT

Thank you for coming to us for your dental care! The office of Dr. Terese N. Fay, DMD, PLLC is committed to delivering the finest in dental treatment. Your clear understanding of our financial and office policies is important to our professional relationship and allows us to concentrate on patient care.

INSURANCE:

Your dental insurance is a benefit plan provided by your employer that offsets dental expenses in full or in part. The amount covered is based on a contract between your employer and the insurance company. The higher the premium paid by your company, the more generous the reimbursement. Dental benefits have limitations to coverage which include **co-pays**, **surcharges** and **deductibles** (an annual fee which must be paid before insurance coverage will be in effect- usually waived on preventive care). Also, insurance plans place limits on how much they will pay over a year (**annual maximum**), how often you may receive coverage (**frequency limits**), types of materials they will cover (**alternate benefits**) and types of services covered.

Your dental health is of the first and foremost importance to us. As such, at all times, you can be confident that we will always recommend care based on your needs for long term optimal dental health and provide you with our best services without regard to the limitations imposed by your insurance coverage. We will, however, work with you and try and maximize your dental insurance benefits to offset any dental costs. We will try our best to estimate your coverage in good faith and we will inform you of best estimates of all costs before treatment is administered.

POLICIES:

I understand that:

1) It is my responsibility to provide the office with a complete and current medical and dental history,
2) It is my responsibility to provide the office with a complete and current address, contact information and any dental insurance information.
3) All fees for services rendered are my full responsibility regardless of insurance coverage. I am responsible for all amounts not covered by insurance including deductibles, co-pays and surcharges.
4) It is the office policy that payment is due at the time service is rendered. For my convenience, the office accepts payments by cash, check and credit card. For more extensive treatment plans, the office offers pre-arranged payment plan options, which allow quality dentistry to be made more affordable to me.
5) **Lab work** (ex. crowns and bridges) and **Invisalign ®:** For dental care involving multiple visits a down payment of approximately one half of my responsibility is required at the beginning of treatment. The balance is due by completion/delivery date unless other arrangements are made.
6) **Broken Appointments/Late Cancellations:** My scheduled appointment time has been reserved specifically for me. As a courtesy, the office will confirm my appointments. The office requests at least 24-hours advanced notice if I cannot keep an appointment. If the office is not notified of my change of plans with at least 24- hours advanced notice, then it will regrettably charge my account a cancellation fee of $85 unless there are extenuating circumstances.
7) Balances over 30 days due will incur 16% annual finance charge (1.33% per month). I will be responsible for any finance and collection charges that may be incurred.

PHOTO RELEASE:

I consent to the taking of photographs by Terese N. Fay, DMD, PLLC of me in connection with my dental care. I understand that such photographs shall become the property of the Practice and may be retained or released for the purpose of preoperative planning, dental records, and publication in print, visual or electronic media. I will not be identified by name in any published photograph. I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation.

My signature below indicates that I have read, understood, acknowledge and agree to the above.

⇨ _____ Date _____ Relationship to Patient: _____

Signature of patient, parent or guardian