Rita M. Cammarata D.D.S., P.A.

PEDIATRIC DENTISTRY

FINANCIAL AGREEMENT

Payment is to be paid in full at the time of services. We accept cash, check, Master Card, Visa, American Express, Discover and Care Credit. Returned checks are subject to a processing fee as determined by TeleCheck. **Please be aware that the parent bringing the patient to our office is responsible for payment of all charges**. If someone other than the parent accompanies the patient, arrangements for payment should be planned in advance.

RITA M. CAMMARATA AND HER ASSOCIATES ARE OUT-OF-NETWORK PROVIDERS.

FINANCIAL POLICY

Agreement of accepting your insurance:

- You must pay the estimated portion of what your insurance does not cover.
- After receiving payment from insurance you are responsible for any remaining balances.
- If insurance fails to pay your claim within 5 weeks of submission, we will request payment directly from you. In the event of duplicate payment from your insurance, we will issue you a refund.

We attempt to provide the most accurate information available regarding your insurance. You should also verify and be knowledgeable about your insurance benefits. Information given to you by us is a courtesy from our office, it is not a guarantee of payment and you will be responsible for any discrepancies. Your insurance is a contract between you, your employer and your insurance company and we are not a party to such contract.

If treatment recommended involves a Space Maintainer or Orthodontic appliance, you will be expected to pay half when the impression of your child's teeth is taken. The remaining balance will either be due by you or filed with your insurance the day the appliance is delivered. Any remaining balances will be directly billed to you.

STATEMENT OF UNDERSTANDING

I have read and understand this information and hereby assign Cammarata Pediatric Dentistry all dental benefits and authorize said assignee to release all information necessary to secure payment. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original.

I AGREE AND ACCEPT THE ABOVE POLICY AND WILL ABIDE BY SUCH. ALL MY QUESTIONS REGARDING THIS POLICY HAVE BEEN ANSWERED.

SIGNED_____DATE_____

THE FOLLOWING INSURANCE INFORMATION IS NEEDED FOR ASSIGNMENT TO BE CONSIDERED:

ARE YOU A NEW PATIENT? _____YES _____NO

IF YOU ARE NOT A NEW PATIENT, PLEASE CHECK ONE:

_____THE INSURANCE INFORMATION ON FILE FOR MY FAMILY HAS CHANGED

_____CAMMARATA PEDIATRIC DENTISTRY HAS NOT PREVIOUSLY FILED CLAIMS FOR MY FAMILY

INSURED'S NAME_____

ADDRESS_____HM#_____WK#_____

INSURED'S DOB_____SS#_____

EMPLOYER_____PHONE#_____

INSURANCE COMPANY_____

GROUP#_____INSURANCE PHONE#_____

INSURANCE COMPANY ADDRESS_____

CHILDS NAME 1)_____2)_____3)_____

CHILDS DOB 1)_____2)_____3)_____

RELATIONSHIP 1)_____2)_____3)_____

FOR OFFICE PURPOSES ONLY: DOE_____VERIFIED W/_____BY_____

Revised 1/2011

cammarata
pediatric dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name Relation to the Patient(s)

_____
Signature (Patient Signature if 18yrs. or older)

_____
Date

May we send a 'Thank You' with your name and your child's name to your referral source?

Yes_____ No_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)