



LOUIS F. CLARIZIO, DDS PA  
ORAL SURGERY & DENTAL IMPLANT CENTER  
DIPLOMATE, AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY

## FINANCIAL POLICY

***Please Read Before Completing Registration***

In an attempt to keep medical costs to a minimum, the following policy regarding fees and billing has been adopted. If you have any questions, please ask the receptionist.

We are participating members of *Northeast Delta Dental, Blue Cross / Blue Shield of NH and Healthcare Value Management*. Patients with these Insurance's will be required to meet the deductible, co-payments or 20% of estimated fees and non-covered services if applicable. For non-participating insurance's, 50% to 100% of estimated fees will be required day of service depending on insurance coverage. For patients without insurance benefits, payment is due in full on day of service. **PLEASE NOTE: if your insurance company requires a referral from your primary care physician, it is your responsibility to obtain one.**

We will bill your insurance Company as a courtesy to you. Professional services are rendered and charged to the patient and not the insurance company. If payment by your Insurance Company is delayed, we request your assistance in hastening the process. Patients are responsible for knowing their insurance benefits. Please be sure to read your Insurance booklet and forms carefully. If you are in doubt as to whether your surgery is covered, or if you have any questions regarding how much of the bill, if any will be covered by Insurance, please call your Insurance Company.

Signing below you agree that in the event that your account becomes delinquent, you will be responsible for collection agency fees and/or attorney/court fees.

There will be a charge of \$30.00 for a returned check. There will be a 1.5% service charge applied to all accounts over 90 days.

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### **Please indicate the method of payment for your bill today**

Cash

Check

Charge

**Print Patient's Name:** \_\_\_\_\_

**Patient or responsible Party's Signature**

\_\_\_\_\_ Date: \_\_\_\_\_

*(Parent or Guardian's signature, if patient is under 18)*

**Please Sign and Print Signature**