

**Kids and Family Dentistry | Dr. Farideh Golestani & Associates**

471 West Mt. Pleasant Avenue | Livingston, New Jersey 07039

Telephone 973-597-1818 | Fax 973-597-1817

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**FINANCIAL POLICY**

1. Patient Portion Payments are required in full at the time of the treatment unless other arrangements are made prior to services being rendered.
2. If the patient has insurance, this office, as a courtesy to you, will submit the claim to the insurance, but it is the patient's responsibility to insure that the bill is paid in full.
3. There is a fee of \$75 for any "missed" appointment. An appointment is considered missed if the cancellation is received less than 48 hours before the appointment is scheduled or the patient is late for more than 15 minutes of the visit.

Driver's License#: \_\_\_\_\_ State: \_\_\_\_\_ SS#: \_\_\_\_\_

Credit Card: \_\_\_\_\_ Exp: \_\_\_\_ / \_\_\_\_ CVV: \_\_\_\_\_

4. This credit card will be used to reserve all appointments scheduled and all other fees for services. Each appointment is reserved exclusively for you. There is a cancellation fee for appointments not cancelled with a 48 hour notice.
5. There will be a charge of \$50 for each check returned due to insufficient funds.
6. Any balance past due for more than 30 days is subject to finance charges at the rate of 18% annually that will be paid to the office.
7. In the event that the account becomes delinquent for more than 31 days, I also agree to pay a finance charge of 1.5% per month on any balance due. As well as all reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account.
8. All charges are the patient's responsibility regardless of any insurance company payments. Not all services are a covered benefit in all plans. **IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR DENTAL BENEFITS.**

I hereby agree to the above terms.

Patient Name: \_\_\_\_\_

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

Signature: \_\_\_\_\_  
(Parent or Guardian signature for minors)