



Our Relationship Guidelines

Even though personal finances and insurance benefits may vary from person to person, at Stefano Dental, we commit to providing the same outstanding level of dental care to every patient without exception. We believe each patient desires and deserves our finest treatment recommendations regardless of insurance limits. We promise to maximize each patient's benefits without letting insurance dictate the quality of care we provide. In return, our educated patients embrace fiscal responsibility for their dental care.

- Your dental benefits are based upon a contract made between you, your employer and an insurance company. Because you are the client of the insurance company, you are responsible for knowing your own dental insurance benefits. We may be able to assist you, but if you have any questions regarding your dental benefits, please contact your employer or insurance company directly.
- We do our best to provide you with an accurate estimate of your patient portion based on the most up-to-date information we have. Because insurance companies change their benefits frequently, this estimate is not a guarantee.
- As a courtesy, we will bill your insurance company on your behalf. If insurance does not pay within 90 days, Stefano Dental will request payment in full from you. You will then work with your plan to get reimbursed by them. Ultimately, you are responsible for all charges incurred in our office.
- We will work with you to maximize your benefits and reduce your out-of-pocket costs. Please be aware that because most plans haven't increased their benefits in the last 60 years, insurance should not dictate your care or be expected to completely cover all your dental needs. It is only meant to assist you.
- Stefano Dental does require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash and checks. If you are in need of an extended finance option, we offer Care Credit, designed to meet your treatment plan needs on approved credit.
- A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 48 hour** notice to avoid a \$50 cancellation fee. This amount is donated to a local charity.

I grant permission for the office staff to contact me by phone call, voice mail message, text or email, regarding appointments. HIPAA CONSENT: I have seen and been given the opportunity to review this office's Notice of Privacy Practices. By signing this form you are consenting to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

I agree with the above conditions.

Print Name: _____ Date: _____

Patient/Parent Signature: _____