ADVANCED DENTAL ARTS OF SOUTH BRUNSWICK
DR RONALD K. KATZ

FINANCIAL POLICY

Payment for all services is due the day of service unless prior arrangements have been made. The following financial arrangements are accepted at Advanced Dental Arts of South Brunswick.

We accept payments in 3rds for treatment under $3000.00
For more comprehensive *treatment plans of $4000.00 or more, a 50% deposit is required* to secure your initial treatment appointment.

Please note:
A courtesy of 5% will be extended when payment is made in full by cash or check before treatment begins.
Payments made in full by credit cards, a 3% discount will be extended.
We offer 3,6, or 12 months deferred interest payments with credit approval through an outside finance company {Care Credit}, credit approval is required.

Form of payments accepted
Cash, Checks
credit cards

DENTAL INSURANCE
Estimates regarding your dental insurance are given as carefully as possible. These estimates are based on information currently available and past history of any specific insurance company. However, your insurance carrier will ultimately decide on the benefit to be released.
Our financial arrangement with you will include your estimated dental insurance, however YOU are responsible for ALL treatment fees. If insurance does not pay within 60 days, Advanced Dental Arts of South Brunswick reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you.
It is important that you recognize that the insurance you have is a legal contract between YOU and the insurance company. Ultimately, you are responsible for all the charges incurred in our office.

MISSED APPOINTMENTS
Cancelled: Any appointments not cancelled within 48 hours of your scheduled appointment in advance is subject to a $50.00 cancellation fee which is applied to your account.
No show: A no show for a scheduled appointment will result in a fee of $30.00 for every half hour of scheduled appointment time.

Patient/guardian name: _____ Date: _____
Patient/guardian signature: _____ Date: _____