

Cavitybusters  
1683 Rt. 88 Suite B  
Brick, NJ 08724

## **Office Financial Policy And Your Dental Benefits**

We would like to welcome you to our dental practice and explain a little about our office policies and goals. We believe in the theories of modern dental care which do not support the old premise of "when it hurts...fix it." Through proper preventive care and regular checkups, we believe that it is highly likely that most of our patients can expect to keep their beautiful smile for many years to come.

### **Our patients can expect from us:**

- A high degree of professional skill and ability.
- A dedication to your oral health.
- A minimization of costly reconstructive work through proper preventive care.
- The highest effort to make your visits as comfortable as possible.
- The right treatment at the right time.
- Fees that are fair and just for the service provided.

### **In return, we expect from our patient**

- Cooperation in making and keeping appointments.
- A conscientious effort toward good oral hygiene.
- Recall visits to maintain optimum oral health.
- Arrangement for the payment of fees at the time of service.

### **New Patients:**

- For those who have dental insurance, we require the estimated patient portions of the total treatment estimate be paid at the time services are rendered. Once we have received payment from your insurance company, any credit balance will be refunded to you promptly.
- For those without insurance coverage, we expect payment in full at the time service is rendered. If this is unlikely for you payment arrangements must be discussed before appointment.
- For emergency patients, balance must be paid in full same day of service.
- For those with appointments, we kindly ask a 24 hours notice for any cancellations. Any cancellations done the day of appointment or any no shows will be subjected to a \$75.00 charge.

**Care Credit:** This is like a dental Visa card. New or existing patients may apply for credit and if accepted be granted a line of credit. This can either pay your treatment off in full, or be used to make payments with. You will then be billed a monthly payment from the credit card company. For further information on this card please feel free to ask one of our staff members.

PLEASE INDICATE HOW YOU WISH TO HANDLE YOUR ACCOUNT:

1. \_\_\_\_\_ I will pay cash/credit card the day of treatment. A 5% discount may be obtained if you prepay your entire treatment on your first visit.
2. \_\_\_\_\_ I have insurance and will pay my portion the day of treatment with cash/check/credit card.
3. \_\_\_\_\_ I have insurance and elect to apply for any and all the outside credit line through third party financing entities, such as Carecredit, capital one (financing) to cover my portion.
4. \_\_\_\_\_ I have no insurance and would like to apply for any/all of the outside credit lines through third party lenders such as Carecredit, and Capital One financing.

When applying for credit, you may apply to more than one outside company. Our staff will be glad to fill in the information portion of the additional credit card forms, but you must read each form and then decide if you want to apply. When you sign the application form our staff will then apply for the credit line with the outside company on your behalf. If you do not want to apply, do not sign the application. You may also apply by going online to [www.carecredit.com](http://www.carecredit.com) and [www.capitalonehealthcarefinance.com](http://www.capitalonehealthcarefinance.com).

I have read this letter and understand its terms, before signing

Please ask for copies of any documents before you leave the office or at anytime. Our staff will be glad to give you copies of any documents relating to your file. We only send Statements to patients who have a balance due. If you want a Statement of your account, at anytime, please ask our staff.

X \_\_\_\_\_

Patient Signature

\_\_\_\_\_  
Today's Date

**CAVITY BUSTERS**  
DR. S. KARAS, D.M.D.  
1683 Rt 88 west, Brick NJ 08724 (732) 836 3002

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Dear Patient:

Our policies have been established to ensure that the best services can be provided to you and your family and you can be fully informed before making the decision on what services you want performed and how you will pay for our services. **We request that you carefully read all documents and understand them before signing them. If you have any questions please do not hesitate to ask us.**

Our professional services are rendered to the patient and not to the insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor.

**WE WILL NOT PROVIDE ANY SERVICES ON THE ASSUMPTION THAT THE CHARGES WILL BE PAID FOR BY THE INSURANCE COMPANY.**

With or without insurance coverage, you are responsible for full payment of your total bill.

**PAYMENT IS DUE AND PAYABLE AS SERVICES ARE RENDERED.**

For your convenience, our office has made arrangements with several outside finance companies and banks such as Carecredit, Medcash and Personal Financial Solutions Inc. These companies offer financing for your dental treatment. These outside companies offer credit lines, some offer low monthly payments and other features such as low or interest free financing and/or extended payment options. **Before you apply for credit you should carefully read and understand the Truth In Lending Statement (TILA) that is part of the application forms. Ask us for these forms.** We will also try to answer your questions or get answers for you from the credit card companies. Applications may be obtained at our reception desk. Again, please carefully read the forms, make sure the information you provide is correct and that you have read the TILA disclosures and understand them before signing the forms. **These outside companies are not associated with this office. Payments are made directly by you to these third party companies.**

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In order for our newly formed relationship to be mutually satisfying and beneficial, we ask that at any time you have a question or are unhappy about any treatment, fee for service, or attitude of our dental team, you will discuss it with us promptly and openly. Misunderstandings and /or lack of communication are the only obstacles to our continued friendship and professional relationship.

Financial Responsibility: I further agree to pay all finance charges, collection cost, Attorney fees, and any other cost that may be incurred to enforce collection of any Amount outstanding.

Sincerely,  
Dr. Karas and Staff

Patients signature: \_\_\_\_\_ Date: \_\_\_\_\_