New Millenium Dental
3733 Richmond Ave.
Staten Island, NY 10312
(718) 605-6324

Patient Financial Responsibility

We are pleased that you have insurance to help offset your out of pocket cost of dentistry. Your insurance is a contract between you, your employer, and the insurance company – we are not a party to that contract. You are responsible for any deductibles, co-payment and non-covered services. Co-payments and/or deductibles are to be paid at the time of your visit. Should your insurance plan covers less than you originally estimated you will be billed for the balance. Any balance left after your insurance pays their portion, must be paid in full by you within 30 days.

Most insurance companies reimburse our office in a timely fashion, however, should your insurance company not remit payment to us within 30 days of their receipt of the claim you will be responsible for the entire balance.Our office offers a payment plan called Care Credit through General Electric Company to help offset your out of pocket expenses.This plan offers you little or no interest depending on which plan is chosen.

If your insurance company does not accept assignment of benefits (they mail the check directly to you in that case) then you are responsible to pay for the services as they are rendered. New Millenium Dental will file your claim and you will then be reimbursed by your insurance carrier directly.

If this account becomes delinquent it will be forwarded to an attorney for collections. You will be billed for any fees associated with the collecting the balance on your account.

By signing this agreement you acknowledge that you have read, understand and accept the above stated financial responsibility. You agree to all of the conditions stated above.

_____ _____
Signature Date

_____
Signature of parent/guardian if under 18

Authorization Of Signature On File

By signing below I authorize New Millenium Dental to affix my name to any and all claims or documents as related to any and all health benefits due me and any of my dependents. I hereby authorize payment of dental benefits otherwise payable to me, directly to New Millenium Dental. To the extent of the permitted under applicable law, I authorize release of any information relating to the claim. A photocopy of this document may act as the original.

_____ _____
Signature Date

_____
Signature of parent/guardian if under 18