Arciuolo Family Dentistry

Dr. Robert A. Arciuolo Jr. DMD
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Office / Financial Policies

Thank you for choosing our dental office! We are committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to treatment.

MISSED APPOINTMENTS: We reserve the right to charge and collect a fee of $30.00 for broken appointments without 24-hours advance notice. The patient is responsible for this charge, insurance will not pay this fee. Exceptions will be made on a case-by-case basis. If you or a family member misses a total of three appointments and you do not give proper notice to our office you may be dismissed from our practice.

DENTAL INSURANCE: We are happy to bill both your primary and secondary insurance carriers as a courtesy for our patients. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Any estimate given by this office is considered a guideline until the final insurance is received, and your account is reconciled. Our office cannot guarantee the actual payments by your insurance carrier.

*We accept the following forms of payment: Cash, Check, Visa and MasterCard.
*Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing coordinator.
*If dentures, partial dentures, crown and/or bridges are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.
*We also offer Care Credit. Care Credit accounts must be approved before services are rendered, so please ask for more information if interested.

*Personal outstanding balances after 30 days from date of service are subject to a finance charge of 1 ½% per month 18% per year. If an attorney is required to collect any unpaid portions of your account, you will be responsible for any collection agency, attorney and/or court costs.
*We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party: _____ Date:_____