

Alan F. Pressman, D.M.D.
250 Old Nyack Turnpike
Spring Valley, N.Y. 10977
845-352-2884

Financial Policy

Payment is expected at the time of service. For your convenience, we do accept Master Card, Visa, American Express and Discover. We ask our patients to give at least 24 hours notice if they must cancel an appointment. We reserve the right to charge your account a missed appointment fee of \$50.00. A \$25.00 returned check fee will be assessed to your account for all returned checks.

Although we are not contracted with any Insurance plans, we will contact your insurance company for you and determine as close as is possible what your portion is to pay on the date of service. This information is an **estimate only** and we cannot guarantee any information to your insurance company on your behalf. After your insurance company pays their portion, we will inform you of what balance, if any, is outstanding for you to pay. This amount will be due upon notification.

Please note that your insurance policy is a contract between you and your insurance carrier. If for any reason your insurance carrier does not pay within forty-five days, as allowed by law, the balance will become your responsibility. If after 90 days there is no attempt at a resolution towards paying the outstanding balance, we reserve the right to charge a monthly fee of \$5.00. In the unfortunate circumstance that your account becomes more than 180 days overdue, we reserve the right to forward your account to our collection agency where you will be responsible for any collection and/or attorney fees.

Our staff is available to answer any questions that you may have regarding our financial policy.

By my signature, I have read and understand the financial policy of this office. If I request to enter into a payment plan or financing of any sort, I hereby give my permission to have this office retrieve a credit report on me. In cases where the payment is being received directly from the insurance company, I authorize payment to this office.

Signature: _____ Date: _____
(Parent or Guardian's signature is required if the patient is a minor.)