167 Avenue at the Common
Suite 16, 2nd floor
Shrewsbury, NJ 07702

Tel (732) 935-0905
Fax (732) 935-0899
www.oceandentalnj.com

Financial Policy

Thank you for choosing us as your dental provider. We are committed to giving you the best treatment possible in order to ensure your health and well-being. Please understand that the payment of your bill is an important part of your treatment, and allows us to acquire the materials neccessary in completing your treatment. Please review and sign our financial policy before the doctor sees you.

Full payment is due at the time of the service. We accept checks, cash, Visa, MasterCard, Discover and American Express.

INSURED PATIENTS:

Your insurance benefits begin when it is verified. Until then, the balance for care provided is your responsibility. We cannot bill your insurance company unless you provide us with accurate insurance information, and a properly completed claim form (if required). Please understand that your insurance is a contract between your insurance company and you. In the event that we accept your insurance benefits, we require that you pay your estimated portion including any co-pays or deductibles at the time of service. Your estimated portion is not a guarantee of your full payment. Final balance is determined after the last insurance payment is received. Balances due on your part is payable within 30 days of notification.

INSURANCE PLANS IN WHICH WE ACTIVELY PARTICIPATE:

All co-pays and deductibles are due at the time of your visit. In the event that your coverage changes to a plan we do not participate with, we must be notified. You must then be responsible for the payments, and we would be happy to submit claims on your behalf.

USUAL AND CUSTOMARY RATES:

We are committed to providing the best treatment to our patients and we charge what is usual and customary for our area. Please understand that you are responsible for payment regardless of any insurance company's arbitrary determination usual and customary rates or non-covered service.

ADULT PATIENTS (Over 18):

Adult patients are responsible for full payment at the time of service by either cash, check, credit cards listed above or an approved credit plan such as Care Credit.

UNDER 18 PATIENTS:

The accompanying adult (parent or guardian) is responsible for full payment.

MISSED APPOINTMENT:

We set aside time in order to care for you. We ask that you keep the appointment that you arrange with us. If you cannot keep the appointment, please give us at least 24 hours notice. We reserve the right to charge $50 for appointment cancelled within 24 hours. The same policy applies for non-notified cancellations.

INTEREST:

We reserve a right to charge a 12% APR or a $5 billing fee for accounts over 60 days.

Thank you for understand and co-operating with our financial policy. We welcome any questions or concerns you may have.

I understand and agree to this financial policy dated _____

Sign here: _____ Print here: _____