Philip F. Jiamachello, D.D.S.
Pediatric Dentistry
Financial Agreement

We find that open communication with our patients regarding our financial policy assists us in providing the best possible service to you. Please take time to read these policies concerning dental insurance benefits. If you have questions, please feel free to ask.

Dental insurance is intended to only be an aid and rarely covers 100% of the total cost of your dental care. Every plan has its own provisions, which we must abide by. Certain costs will be passed along to the patient, such as deductibles, and co-insurance amounts. As a patient, you have certain responsibilities: (1) to pay amounts not covered by your insurance carrier at the time services are rendered (2) to be knowledgeable about your plan's covered and non-covered services (3) to notify the registrar if there are any changes in your coverage. We will do our best to work within your plan to help you receive maximum benefits. Please be advised that responsibility for full payment is solely yours, whether or not you have insurance. There is a **$30** fee for all checks returned for insufficient funds. Pediatric Dentistry reserves the right for all future payments by the undersigned to be paid in cash, credit card, or money order.

Secondary Insurance: Patients who are covered by more than one dental insurance carrier should notify the receptionist at the time of registration. It is your responsibility to know the limitations of your secondary policy. If you have two insurance policies, the deductible and co-payment of the primary insurance is collected at the time of service. Once both insurances have paid if your account has a credit balance Pediatric Dentistry will reimburse you.

Acknowledgement as Signer on the Account:

Upon my signature below, I attest that I have read and understand all the provisions discussed herein. Any questions I have asked have been answered to my satisfaction and to the extent where I can place my signature on this document. I understand my rights and obligations as a patient of Pediatric Dentistry. Should the patient be a legal minor I hereby attest as the signer below, that I am the lawful guardian of the minor.

I authorize that my insurance benefits be paid directly to Philip F. Jiamachello D.D.S.
I acknowledge that I am responsible for full payment of services rendered. I have read the above information carefully, and agree with all of the terms.

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Patient's Name (Print)

____ ______________________________
Parent/Guarantor or Responsible Party if Patient is a Minor Date

____ ______________________________
Witness Date

Appointment Policy Guidelines
Philip F. Jiamachello, D.D.S.
Pediatric Dentistry

You will receive a courtesy reminder call from our office 48 hours prior to your scheduled appointment. Your child's oral health is of utmost importance to us. Please understand that this time is reserved especially for your child.

If you must change your appointment, call us at least 24 hours in advance. A missed appointment is time that could be used to benefit another child. Without at least 24 hours' advance notice, our office will consider the appointment broken.

If two appointments are broken without proper advance notice, we may be unable to schedule additional appointments for you, and Philip F. Jiamachello, D.D.S. reserves the right to dismiss the patient from our practice. The practice will offer emergency treatment for a thirty (30) day time period from the date of the missed appointment. After that the patient will no longer be treated at Pediatric Dentistry.

We make every effort here at Philip F. Jiamachello's office to be on time for our patients' appointments and ask that you extend the same courtesy to us. When you are late for an appointment, other patients may be kept waiting. Please be on time or early for each appointment.

I have read the above statement and have agreed to abide by this policy. Any questions or concerns have been appropriately answered by the staff of Pediatric Dentistry.

Please bring your insurance card and/or Medicaid card at each visit.

We thank you for your cooperation and understanding of our practice guidelines.

____________________________________ Date ____________________
Patient's Name (Print)

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Signature (Relationship to Patient)

____________________________________ Date ____________________
Witness