

WELCOME TO DR. MAGRI'S OFFICE

INFORMATION FOR OUR PATIENTS: Please turn off all pagers and cell phones

FOR YOUR BENEFIT: We take into consideration your schedule and try our best to keep your appointment time, however, due to unforeseen emergencies, if we over run our appointments we ask that you please be patient. We will provide you with a treatment plan, which will outline your treatment and fees. If you have any questions regarding treatment and or fees, please do not hesitate to speak to the front office.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):

For your protection, our office abides by all Federal and State regulations to protect your private health information.

FINANCIAL POLICY: Payment for services rendered is due at the time of service. If insurance is applicable, you are responsible for your portion at the time of service. We offer the following payment options:

- Coordination of Insurance Benefits
- Cash / Personal Check
- VISA/MC/DISCOVER/AMEX
- **Care Credit** Financing

INSURANCE: We accept assignment of benefits in most cases. The patient portion of fees is COLLECTED AT TIME OF SERVICE. **WE DO NOT BILL SECONDARY INSURANCE.**

- No insurance company will cover 100% of all dental expenses. We can only **estimate** insurance payments. We do our best to collect from the insurance carriers on your behalf, but **YOU ARE RESPONSIBLE FOR THE UNPAID BALANCE. You are responsible for your bill regardless of any insurance companies' arbitrary determination of usual and customary rates or non-payment of services rendered to you.**
- The estimated insurance portion is due within 60 days. Therefore, if no payment has been made after 30 days please contact your insurance company and inquire about your claim. If after 60 days no action is taken on your claim, it is then due by you to us.

BROKEN APPOINTMENTS: There is a \$50.00 cancellation fee for all appointments broken with less than a 48-hour notice. We thank you for your cooperation.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND I ACKNOWLEDGE THAT I HAVE READ THE NOTICE OF PRIVACY PRACTICES AND CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION.

Signature _____ Date _____