

DR. Mark Groskin & Associates  
1109 English Rd.  
Rochester, NY 14616  
585-225-7070

## FINANCIAL POLICY

This is an agreement between Mark I. Groskin DDS & Associates and the patient named on this form. By executing this agreement, you are agreeing to pay for all services that are received for yourself and all immediate family members in your household, (this includes insurance payments of course!)

**Payment options if you have no insurance: We currently offer a 20% discount to patients without insurance.**

You choose to pay by    cash,    check, or    credit card on the day that treatment is rendered. On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and the balance at the time of the insert. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution. We offer special financing through Care Credit. The Care Credit plan is similar to a credit card. We will give you a 1-800 number to call, they'll ask you for some information, we'll tell them how much your treatment plan cost, and they will tell us if you're approved for a loan and you would make low monthly payments directly to them. If you're interested in Care Credit please ask Donna at the front desk.

**WE DO NOT BILL OUT OF POCKET EXPENSES: THEY MUST BE PAID AT THE TIME OF SERVICE.**

**Payment options if you have insurance:**

You choose to pay your deductible (if applicable) and any out-of-pocket portions at the time services are rendered by    cash,    check, or    credit card. (This option applies if Dr. Groskin participates with your insurance.)

You choose to pay all of your treatment by    cash,    check, or    credit card. We will request your insurance carrier send their payment directly to you. (This is mandatory if Dr. Groskin does NOT participate with your insurance).

On extensive treatment (crowns or bridges) you may choose to pay 50% of your out-of-pocket portion on the start or preparation date, and the balance on the completion or delivery date. (Normally three weeks later.)

**Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance insurance company.

**Required payments:** Any co-payments required by an insurance company must be paid at the time of

service. Because this is an insurance requirement, we cannot bill you for these.

**Patients over the age of 18 are responsible for their account, unless we receive a written letter from parent.**

**Returned checks:** There is a fee (currently \$35) for any checks returned by the bank.

**\*\*Missed appointment fee\*\*:** *If at any time a patient does not show up on time for an appointment, or cancels with less than 48 hours notice, a \$35 fee will be charged. (Excluding emergency situations of course) This fee must be paid before a new appointment is scheduled.*

**Past due accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. If your account is transferred to collections, we will have to dismiss you as a patient.

**Waiver of confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child (the parent who brings the child in for treatment) will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Not Dr. Groskin's office.

**Transferring of Records:** You will need to request in writing, and pay a reasonable copying fee (currently \$15) if you want to have copies of your records sent to another doctor or organization.

**Co-signature:** If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions c By signing, you are stating that you have reviewed the financial policy, listed below, and agree to all terms and conditions contained herein:

PATIENT NAME: \_\_\_\_\_

RESPONSIBLE PARTY (If not the patient): \_\_\_\_\_

Please list all family members you are financially responsible for:

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Co-Signature (Spouse): \_\_\_\_\_ Date: \_\_\_\_\_