ROBERT TRACEY D.D.S., F.A.G.D
Building Relationships While Rebuilding Smiles

11 Medical Park Drive
Pomona, NY 10970

FINANCIAL POLICY

I ____, understand and agree that it is my responsibility to be familiar with my dental insurance policy. I agree to provide correct insurance information. I will pay in full at the time of service if I do not have this information, and I accept responsibility for payment of the entire bill.

Furthermore, I understand that your office will bill my insurance company as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you be responsible for collecting the funds that are due to you. This is rare, but it is important that your recognize the insurance policy is a legal contract between you and the insurance company. Our office is not, and cannot be part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

APPOINTMENT NON-COMPLIANCE CONTRACT

I understand to be here, on time, for my scheduled appointment. Dr Tracey's office provides reminder cards at the end of each appointment for my future appointments. If I am unable to keep my appointment, or fail to show up for my appointment I will be charged a $75.00 appointment non-compliance fee for every 1/2 hour scheduled. I need to give at least 48 hours notice. Payment for this fee will be my responsiblity.

I agree that if my balance due to Dr Robert Tracey, DDS, FAGD remains unpaid I will be reponsible for interest on the unpaid balance at the rate of 18% per annum, plus cost of collection and reasonable legal fees.

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Name	Signature	Date

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