

NORTH PENN DENTAL ARTS
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FINANCIAL POLICY

PATIENTS WITH INSURANCE COVERAGE:

North Penn Dental Arts will assist you in obtaining the appropriate benefits from your insurance company and will bill your carrier as a courtesy to you. However, it is the responsibility of the patient to pay his/her estimated portion of the fee at the time of service. At your request we will process a pre-treatment estimate of benefits from your insurance carrier. Routine treatment is generally performed without prior authorization.

In the event of single and/or dual coverage, we will submit the services to both primary and/or secondary insurance carriers. However, you will be responsible for payment after primary insurance is estimated, and an additional payment may be required after your secondary insurance has processed the claim.

PATIENTS WITHOUT INSURANCE COVERAGE:

Patients without insurance coverage are required to pay at the time services are rendered. We accept cash, check, MasterCard, VISA, American Express, Discover and Care Credit.

GENERAL ANESTHESIA:

A deposit of \$197.00 is required to schedule an anesthesia consultation appointment.

A deposit of \$500.00 is required to schedule a general anesthesia appointment. In addition, 50% of the estimated co-payment is due 2 weeks prior to the general anesthesia appointment. The balance is due at the time of service.

MAJOR SERVICES:

A 50% non-refundable deposit is required at the time of scheduling any major services. These services include, but are not limited to crowns, bridges, implants and whitening.

A deposit of \$100 is required to schedule a root canal appointments.

CANCELLATION FEE:

North Penn Dental Arts requires a 48 hour (2 business days) cancellation notice. If appropriate notice is not given a \$75 fee or 50% of the estimated treatment cost (whichever is higher) will be charged.

ADDITIONAL TERMS:

Returned checks are subject to a \$40.00 processing fee. Accounts unpaid after 30 days are subject to a late charge. If your account is referred to our collections department, you will be responsible for all collection costs.

I UNDERSTAND AND AGREE TO THE ABOVE TERMS OF THE NORTH PENN DENTAL ARTS FINANCIAL POLICY.

PRINT NAME OF PATIENT

SIGNATURE OF PATIENT/GUARDIAN

DATE 6/2020