YOUR SYRACUSE

FAMILY DENTIST

VINCENT D. DIMENTO DMD

Welcome To

It is an honor and a compliment to have you as a patient!
Come in and Let Us Show You the Difference!

Thank you for taking the time to review our OFFICE POLICIES.
Please let us know if you have any questions or concerns. We are here to assist you.

Patients cannot be seen until all paperwork is read signed and completed
Minors must have a guardian signature

APPOINTMENTS:

- Any patient under the age of 18 must be accompanied by a parent for all appointments
- Reminder appointment phones calls and 2-week reminder postcards are a courtesy to our patient's. Please understand it is your responsibility to know when your appointment is. If a message is left PLEASE call to confirm you received the message.
- Non-emergency cancellations on the same day may result in a fee as well. Please help us to serve you better by keeping scheduled appointments. Kindly give 48 hours for any cancellation. Missed appointments can result in a fee.

EMERGENCY COVERAGE: Please contact our office. Our office has 24 hour coverage.

INSURANCE & FINANCIAL INFORMATION: We submit and file all of your insurance claims for you as a courtesy. Please verify with our office staff any questions pertaining to your insurance. We will gladly do a courtesy benefits check for you. Please notify us of ANY changes in your insurance coverage **PRIOR** to your visit. *Our office **does not** participate with Medicaid or Medicare.*

If you have insurance, we will gladly help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of your insurance and our financial policy. Please ask if you are unsure of anything. We require a copy of ALL insurance identification cards and a copy of a patient's license or ID card.

Please be familiar with all your insurance terms and frequencies. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. (See our link on our web page for further information on area rates) *You are responsible for payment regardless of any insurance company's "arbitrary" determination of UCR (usual and customary rates) quote.*

Many insurance provider directories are not up to date and sometimes we cannot access that information as quickly as needed. We MUST emphasize that as medical care provider, our relationships is with you, NOT your insurance company. We will gladly submit all forms needed for a "pre" authorization for treatment to your insurance company for you. If an insurance carrier has not paid within 60 days of billing, any unpaid balances are due and payable in full from you immediately.

Cash, Check, Visa, MasterCard, American Express, Discover Card, Flex Account Cards, HSA, Care Credit and Springstone are gladly accepted

Dr DiMento also offers several different payment options plans, from short-term to long-term – please ask at front desk.

We will submit for insurance's providing:

- All patient forms are filled out and the information is correct
- We are able to verify coverage by telephone or internet and have a complete mailing address and current phone number

Please be prepared at appointment time to pay your estimated patients responsibility portion not covered by your insurance. Please understand that payment of your bill is considered part of the treatment. Interest will accrue and will be added to all accounts over 60 days post insurance payment. Any disputes with balances due must be brought to our attention within 30 days of 1st billing.

We realize that temporary financial problems do arise and we encourage you to contact us promptly for assistance in the management of your account. To avoid any misunderstandings, we invite you to discuss any financial problems or hardship you may have with our office. Please inquire as to payment options that our office may offer.

ASSIGNMENT OF BENEFITS:
I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree this authorization will cover all medical services rendered until such authorization is revoked by me in writing. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health status or changes in my insurance status prior to appointments. In the event my account is assigned for collection, I agree to pay an additional collection fee – the greater of $25.00 fee or 30% collection fee based on the total amount overdue as well as any associated attorney fees.

PLEASE READ AND SIGN THIS RELEASE AT FRONT DESK ON SIGNATURE PAD

Thank You & Have a FANTASTIC day ☺