Clarke Street Family Dental

16 Clarke Street Suite 15
Lexington, MA
02421

Dr Silva Andonyan D.M.D and Dr Min Chao D.M.D

Patient Name;

By signing below, I understand that:

A. A treatment plan will be presented to me, listing the procedure(s) that will be done.
Initials_____

B. The office will submit to my insurance an estimate of the total cost of treatment. I understand that this is just an estimate and not an exact amount of what I would owe. Also, should treatment take place without an estimate I understand that there is no guarantee that the insurance will cover the procedure for whatever reasons and that I am fully responsible for the cost of the entire treatment.
Initials_____

C. This treatment plan may change during the treatment based on conditions found while working on teeth that were not discovered during examination. I give my permission to the dentist to make any changes with further consent. I also understand that this would change the treatment fees and again there would be no guarantee that the insurance would approve said changes.
Initials_____

D. I assume full responsibility of payment of all such services regardless of insurance coverage and agree to pay at or before completion of treatment unless other agreements are agreed upon in advance with the doctor office. Initials_____

E. I understand that for my treatment to begin without delay and to maximize its effectiveness I must notify this office as far in advance as possible regarding changes to scheduled appointments and that there may be fees for no or late notifications Initials_____

Signature _____Date _____

Clarke Street Family Dental

16 Clarke St Suite 15
Lexington MA
02421

In an effort to avoid any misunderstandings, we would like to review our financial and office policies before you begin treatment with our office.

Payment is excepted at the time services are performed. We except Master Card, Visa Discover, and American express.

Although payment is excepted at the time of service occasionally when a balance does remain, payments that are not made in a timely manner are subject to a finance charge.

For our patient with dental insurance our policy's is as follows.
You will need to supply us with the employee information (Name, Date of birth, Social Security number, Employer ID# and employer name) as well as the name and address of the insurance company. We will do our best to answer any questions you may have about your insurance coverage but always suggest that you call or visit your insurance company's website and review your insurance policy's handbook.

As a courtesy to our patients, we will gladly submit the insurance claim to your insurance company. We will collect your estimated co-payment and deductible at each visit. We make every effort to determine your insurance benefits when your receive treatment but please consider your co-payment an ***estimate*** until we receive actual payment for your insurance company. Please remember that any information we provide relative to your insurance coverage is based on what is relayed to us by your insurance company via website or telephone conversation.

Appointment Policy
We reserve appointment times specifically for each patient so that we may provide the ultimate in service. Please schedule your appointment carefully as there will be a charge to your account for any appointment cancelled without 24 hour notice. Similarly, late arrivals can create a scheduling problems with our patients. Please notify us if you are going to be late. If you have any questions about any of our policies, please feel free to ask any member of our front desk team.

Signature_____ Date _____