Cranford Family Dentistry
Robert N. Rizzi, D.M.D.
228 Saint Paul Street
Westfield NJ 07090

Financial Policy

Our primary goal is not to allow the cost of treatment to prevent you from benefitting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable. Please read the following carefully and ask us any questions you might have. We will do our best to answer them for you.

- **Patients without insurance coverage need to know..**
  The fee for the treatment rendered must be paid in full on the **day** of service.

- **Patients with insurance coverage need to know...**
  Please be aware that we are happy to verify your insurance benefits **as a courtesy** to you and to obtain necessary information for your care. We recommend that all patients verify their own benefits as well, to ensure they are fully aware of any limitations and responsibilities they may have. This includes reaching their annual maximum benefit. Please understand that you are ultimately responsible for all fees generated by our treatment.

- **We accept Visa, MasterCard, Discover, American Express, checks and cash for payment of the amount due.** Payments plans are available. Please ask about them if you need one.

- **Two business days notice is required for rescheduling/canceling appointments.** If you do not notify our office within two business days of your appointment, a $50 fee will be applied to your account for rescheduling, canceling or failing to show up for your appointment. Dr. Rizzi reserves your appointment time exclusively for you.

In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all reasonable collection costs not to exceed 50%, court costs, attorney fees and interest accrued with the collection of this account.

By signing this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: ____
Responsible Party (if patient is under 18 years old):

Signature: ____ **Date:** __________________