Daniel M. Sweeney, DDS

753 Titus Ave. Rochester, NY 14617 | 585-266-4860 | SmilesofRochester.com

Office & Payment Policies

Thank you for choosing our office for your dental care. We desire to help you love your smile and keep it healthy and long-lasting. Please find below pertinent information on our office policies.

OUR PAYMENT POLICIES

- You are responsible for payment of all services rendered to you or your dependents regardless of your dental insurance, along with any associated costs or fees incurred by Daniel M. Sweeney, DDS to collect any balance owed.
- Daniel M. Sweeney, DDS requires payment in full for services, or any applicable co-pays or deductibles at the time of service. We accept MasterCard, Visa, Discover, American Express, Care Credit, cash and checks.
- If you are in need of an extended finance option, you must notify us prior to receiving treatment.
- The single exception to payment in full at your appointment (or all expected co-pays) is of any unexpected co-pays that remain after your insurance benefits have paid on your behalf (when your insurance pays less than expected). If this is the case, we will send you a bill due upon reciept.

PAYMENT PLANS

So you may continue now with a complete dental treatment plan that is best for you, we offer payment plan options as follows:

1. These are only by request, and must be discussed prior to receiving treatment or within 10 days of reciept of your first bill.
2. Option #1: Care Credit. We can help you apply to Care Credit for terms up to 18 months, some with no interest if paid in full within their timeframe. Longer terms are also available with an interest bearing revolving charge.
3. Option #2: Through our office. For established patients we extend up to 3 months for a payment plan. We are offering to provide dental services to you on *credit* and anticipating your future payment. We reserve the right to approve or deny a request for a payment plan. Upon approval, we will outline a specific plan for you with expectations of due dates and late fees explained if the apply.

MISSED APPOINTMENTS

A specific amount of time is reserved especially for you and we strongly encourage you to keep your appointments. Missed appointments are costly, and limit us from being able to offer your time to another patient waiting for care. If you must change your appointment, we require 48 hours' notice to avoid a $50 per hour cancellation fee (unexpected emergencies are an exception; please notify our office). If a patient has repeated missed appointments or last-minute cancellations, they may be asked to seek dental care at another office.

OVERDUE BALANCES

- We reserve the right to charge interest on accounts not paid within 30 days.
- For outstanding balances we have made numerous attempts to collect on, we will involve a collections agency or legal entity, and may also report the account to the credit bureau. Collection procedures will be applied consistently and fairly for all patients regardless of insurance status.
- Any associated fees for sending an account to collections or another legal entity (including small claims court) will be added to the account balance. This includes added administrative fees for preparing your account for collections proceedings.
- Outstanding balances will be billed/ collected based on our current financial policies for Daniel M. Sweeney, DDS. An updated copy of our policies is available at our front desk or by request.

Payment Policy Agreement & Insurance Authorization

_____

Print Name of Patient

By signing below, I hereby acknowledge that I have received a copy of, been advised of and agree to the current payment and collections proceedings of Daniel M. Sweeney, DDS. This pertains to me as a patient, or the *legal authority* (parent or guardian, etc.) of the patient listed above. I have had the opportunity to ask any questions. I am aware that an updated payment policy is available in the office and by request.

Further, when dental insurance applies, I authorize the dentist to request my insurance company to pay my benefits directly to the dentist that would otherwise be payable to me. Regardless of insurance benefits. I understand the full charges for any services I incur are my responsibility.

X _____ _____

Signature of patient OR personal representative Date

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Patient Registration

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Patient Information

Address: _____ Address 2: _____

City, State Zip: _____ Home Phone: _____

Cellular Phone: _____ Work Phone: _____ ext. _____ Pager: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Driver's Lic: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

Pref. Dentist: _____ Employer ID: _____ Carrier ID: _____

Pref. Hygienist: _____ Pref. Pharmacy: _____

Email Address: _____ ☐ I would like to receive correspondence via e-mail

How did you hear about our office? _____

Responsible Party (if someone other than patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State Zip: _____ Home Phone: _____

Cellular Phone: _____ Work Phone: _____ ext. _____ Pager: _____

Birth Date: _____ Soc. Sec: _____ Driver's Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship to Assured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Ins. Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Address (street, city, state, zip): _____

Ins. Company: _____ Address (street, city, state, zip): _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Assured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Ins. Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Address (street, city, state, zip): _____

Ins. Company: _____ Address (street, city, state, zip): _____