Dennis W. Sindel DDS
Lloyd P. McDonald DDS
Melissa A. Johndreau DDS
Yuvika Raj Kumar DDS

PATIENT FINANCIAL AGREEMENT

Thank you for choosing the professionals at Coastal Connecticut Dentistry to serve your dental needs. We are committed to providing excellent care. Please understand that payment for your dental care is part of your treatment. Please read and sign this statement.

PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND / OR CARE CREDIT: As a courtesy, we will submit any dental insurance claims on your behalf. **Deductibles and patient portions are collected at the time of service**. Additionally, we have a partnership with Care Credit which allows our patients to make small monthly payments, interest-deferred, for up to 12 months. (See Care Credit plan details.)

REGARDING INSURANCE: We may accept assignment of benefits for your insurance policy. However, all fees are your responsibility. If your insurance company has not paid in full within 45 days, you are responsible for full payment of your account and have 10 days to remit full payment to our office. Please be aware that some, perhaps all, of the services provided may be non-covered services per the level of plan as determined by your employer and the insurance company.

REASONABLE AND CUSTOMARY FEES: Our practice is committed to providing the best dental care for our patients and we charge fees which are usual and customary for our area. Patients are responsible for payment regardless of any insurance company's arbitrary determination based on their premium and coverage negotiations with employers.

MISSED APPOINTMENTS: When given notice of cancellation at least 24 hours prior to your scheduled appointment, we are able to offer that reserved time to another patient to receive professional dental care. Forgotten, missed, or short-notice cancellation appointments will incur a fee of $75. We will reschedule your appointment once the fee is paid. Insurance will not cover this charge.

I have read and I understand the Patient Financial Agreement.

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Print Patient Name | Patient Signature

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Responsible Party | Date