3 Medical Dr, Ste D
Port Jefferson Station, NY 11776
Tel: (631) 928-7500
Fax: (631) 928-7501
www.SmileShack.com

Authorizations and Financial Policy

Appointments - In order to provide each patient with the individual care and attention, we ask that you arrive on time for your scheduled dental appointments. We work hard to see each patient at his or her scheduled appointment time.

Cancellations - We kindly ask you to inform us at least twenty-four (24) hours notice if you need to change your scheduled dental appointment. Less than 24 hours notice, or not showing up for an appointment is considered a missed appointment. A **fee may be charged** for each missed appointment.

Payment - Our mission is to make the cost of optimal care as easy and manageable as possible. It is our policy that ***payments be made at the time of treatment***. Payments can be made by:

- Cash/Personal Check, Debit Card
- Visa, MasterCard, American Express, Discover
- CareCredit (subject to credit approval)

Insurance - Our office will strive to make dental care for you and your family as affordable as possible. We file your claims with your insurance company to maximize your benefit and directly bill them for reimbursement for your dental treatment. Please keep in mind that:

- Dental insurance benefits do not work the same way as medical insurance benefits.
- Every insurance plan is different.
- Co-payments are due at the time of treatment.
- You are responsible for your deductible every year.
- Claims are made at the time of treatment and if not paid in 60 days, you are responsible for your treatment fees and collection of benefits directly from your insurance carrier.
- Benefits cannot be carried over from year to year. If the maximum benefit is reached for the year, you will be responsible for the remaining treatment provided that calendar year.

I, _____, hereby authorize my insurance benefits to be paid directly to Victoria E. Shack, DDS, PC. I understand that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature _____ Date _____

Patient Name (Please print) _____ Relationship _____

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