RUSSO
FAMILY DENTAL
321 Washington Street
Gloucester, Massachusetts 01930
Phone: 978-281-1337

Financial Policy

We appreciate the opportunity to serve you and will make every effort to provide you with quality dental care.

Payments for services are due at the time the services are rendered unless payment arrangements have been approved in advance by our office manager.

For your convenience, we accept cash, check, Visa/MC, American Express, Discover and Care Credit.

Patients who have dental insurance, it is your responsibility to verify that your insurance company will accept Dr. Russo as a provider. There is usually an "800" customer service number which you may call to get this information.

The following points are important for you to understand:

1. Your insurance policy is a contract between you (the subscriber), your employer, and the insurance carrier. We are not a party to that contract. Our relationship with you is a professional one. While the filing of insurance claims is still a courtesy we extend to our patients, all charges are your responsibility from the date of services are rendered, whether your insurance company pays or not. Not all services are a covered benefit and most services will not be paid in full by them. The balance due will be your responsibility.

2. If the insurance company does not pay their portion within 45 days we may require you to pay the balance and see reimbursement from your insurance company directly.

3. In cases of divorced parents, the parent who brings the child will be deemed responsible for payment and is expected to work out financial obligations privately with the other parent.

All patients:
Any check returned to us by the bank due to insufficient funds, etc. will result in a $25.00 service charge to your account.

Bills are sent from this office on a monthly basis with a statement mailed to your billing address. Payment is expected by the due date on the bill. We utilize a collection agency for inactive balances over 90 days old.

NOTE: We realize that temporary financial problems may affect timely payment of your balance, but it is your responsibility to communicate any such problem to us in writing or via telephone so that we can assist you in the management of your account.

Multi Visit Treatments
For all procedures exceeding $200/ multi-visit treatment, 50% of the patient's balance or copay is due at the start of the procedure, with the remaining 50% due at completion of the procedure.

By signing this I understand and agree to the financial policy as stated above. I understand I am ultimately responsible for payment.

Signature ____ Date ____/____/_______

Name ____

Relationship to Patient ____