NILY ABRAMOVITZ DMD PC

Payment Policy

Thank you for choosing our practice as your dental health care provide. We are committed to the success of your dental treatment and want to provide you with the best service available. To help reduce our administrative costs and keep our fees to you as low as possible, we require payments to be made at or prior to the time that you (or your family members) receive treatment. Please indicate below the method of payment you intend to use.

My preferred payment option is:

______Cash
______Check
______Major credit card (Visa, MasterCard, American Express or Discover)
______ ***

A note to patients with dental insurance

Dental insurance usually does not cover the total cost of your treatment. Based on your plan, we usually can estimate the amount of your co-payment. When treatment is delivered to you, your co-payment will be expected at that time. If your insurance company fails to pay within 60 days after we submit your claim, you will be responsible for the full fee.

*** For treatment amounts over $300, please inquire the possibility of an extended payment plan.

Acceptance Agreement

I understand and agree with the above financial policy. I understand the parent or relative bringing a child to dental treatment is responsible for all fees incurred at that visit. I further understand that I am responsible for ALL fees, regardless of insurance coverage.

Patient/Responsible Party ______________________
Printed name

______________________ ____________
Signature Date