PERIODONTAL ASSOCIATES
NEW JERSEY

PATIENT FINANCIAL POLICY FORM

If you have dental insurance, please be advised that our practice participates solely with Delta Dental. All other insurance companies will pay YOU on an out-of-network basis. All Delta Dental patients are responsible for all deductibles. For patients who do NOT have Delta Dental coverage, we will prepare and mail your claims to your insurance carrier as a courtesy. Payment from these claims will go directly to you.

Dental Insurance Information
Policyholder Name: _____
Group#: _____
Policyholder Date of Birth: _____
Policyholder Social Security #: _____
Employer: _____
Relationship to Patient _____Self _____Spouse _____
Child Insurance Carrier: _____
Insurance Carrier Address: _____
Insurance Carrier Phone Number: _____
If you have secondary insurance, please advise us and we will accommodate you by mailing out your primary insurance payment and explanation of benefits to your secondary.

NOTE: I hereby authorize and guarantee payment for all services rendered. Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received. In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 2% per month on any balance due, as well as all reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account. I understand and agree to the terms of payment set forth above.

Name: _____

Signature:_____

Date: _____