Comprehensive Family Dentistry

Financial Responsibility Policy

Thank you for choosing Connie F. Cicorelli, D.D.S., P.A. ("Cicorelli Dental Group"). We are honored by your choice and are committed to providing you with the highest quality care. Please read and sign this form to acknowledge your understanding of our patient financial policies.

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. We accept the following for payment: cash, check, MasterCard, Visa, Discover and American Express.

- It is important for you to provide our office with the most correct and updated information about the patient's insurance, and the patient is responsible for any charges incurred if the information provided is not correct or updated.
- For all new and uninsured patients, payment is due at the time of service, unless a signed financial agreement has been approved by Cicorelli Dental Group.
- Dental insurance is a contract between you, your employer and an insurance company which agrees to pay certain benefits when dental costs are incurred. **We are not a party to that contract, are not an in-network provider and are not responsible for knowing the specifics of your insurance plan.** It is the patient's responsibility to know their insurance policy and what it does and does not cover, including deductibles, out of pocket expenses, maximum benefits and frequency limitations. If your insurance company requires a referral you are responsible for obtaining it. If your insurance company requires a pre-authorization/pre-determination you are responsible for informing us and we will complete the paperwork. Failure to obtain the referral and/or pre-authorization/pre-determination may result in a lower or no payment from the insurance company and the balance due is your responsibility. The patient is the one receiving the dental service and therefore is ultimately responsible for all charges on the account regardless of any insurance coverage. This applies to everyone in the family who is treated by Cicorelli Dental Group.
- As a convenience to you, we will submit your insurance claim to your primary insurance company. If your insurance sends the reimbursement check directly to you, you are required to pay for your appointment at the time of service.
- If the patient has coverage with a second insurance company, all balances are due after primary insurance payment has been received. We will not submit secondary insurance claims. However, we will provide you with any pertinent information necessary for you to submit your claim.
- You may incur, and are responsible for, the payment of additional charges at the discretion of Cicorelli Dental Group. These charges may include (but are not limited to): (i) a monthly billing charge should your account become past due; (ii) charge for returned checks; (iii) any cost associated with collection of patient balances.

Insurance eligibility is not a guarantee of coverage and actual benefit payments are determined by your insurance company only when a claim is processed. By signing below, I understand that I am responsible for any co-payments and deductibles, along with any procedures that my insurance company does not cover. I authorize Cicorelli Dental Group to release any information, including diagnosis and records of treatment rendered to my family, or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I also agree to make immediate payment for all or any portion of my insurance claims not paid within 60 days of service. If legal action is initiated to collect amounts due, you agree to pay pre and post judgment interest, court costs and attorney's fees that may apply, as allowed by the law and court.

I have read and understand the above and I agree to be responsible for payment of all services rendered and any billing and/or collection fees accumulated on my behalf or that of my dependents.

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Patient's Name (PLEASE PRINT)

_____ _____

Signature of Patient (Parent if a Minor) or Responsible Party Date

Signed at:
Cicorelli Dental Group
1401 Silverside Road ● Unit #2a ● Wilmington, DE 19810
Phone: 302 – 798 – 5797 ● Fax: 302-798-9232