Robert F. Sibilia, DMD
25 North Main Street | Mansfield MA, 02048 | (508)339-8231
www.robertsibiliadmd.com

Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care so that you may attain optimum oral health.

The following is a statement of our Financial Policy. Please read carefully and sign prior to treatment. If you have any questions, do not hesitate to ask our staff. We believe good communication is the key to excellence in dental care.

- PAYMENT IS DUE AT THE TIME SERVICE IS PROVIDED...
  Our office accepts cash, personal checks, all major credit cards as well as debit cards and flexible spending cards. We also offer Care Credit which is an extended payment plan with prior credit approval. Please note: Additional fees will be applied for returned checks. All account balances over 60 days are subject to a late fee.

- PATIENTS WITHOUT INSURANCE COVERAGE...
  The fee for the treatment rendered must be paid in full on the day of service.

- PATIENTS WITH INSURANCE COVERAGE...
  The estimated patient copay and deductible for the treatment rendered must be paid in full on the day of service.

  As a courtesy to you we will electronically process all of your dental insurance claims. We will provide an insurance estimate to you if requested; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. We strongly advise you to contact your insurance company for a detail of your benefits. Please understand that you are ultimately responsible for all fees generated by your treatment. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment.

- MISSED APPOINTMENTS AND CANCELLATIONS...
  We require 24 hour notice if you are unable to keep your appointment. We reserve the right to charge a broken appointment fee if proper notification is not provided. Please understand that we set aside a specific time especially for you and not keeping this scheduled appointment time can prevent other patients from receiving timely treatment.

- CONSENT...
  I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient/Parent Name (printed) _____

Patient/Parent Name (signature) _____

Date _____