FAMILY
it's how we treat our patients

GINA LIGGIO MAESTRI, DDS

Our Policy Regarding Dental Insurance

We want you to know that we will go above and beyond to help you maximize your dental benefits. As a courtesy, we will file your claim electronically to save you the time. You are fortunate to have dental insurance! *Quality care for your teeth is the best investment you can make.*

Regardless of what we calculate your insurance company to pay, it is only an estimate. The information we obtain from your insurance company is limited and may have exclusions or unknown clauses. Understand these things are out of our hands. We cannot guarantee what they will pay.

Our Policy on Un-Paid Balances

Estimated out of pocket payments are due at the time of service. You are responsible for any "uncovered" service or difference in our estimated amount and what your insurance company **actually** pays.

Please remember that financial obligation for dental treatment is between you and this office and is not between this office and your insurance company.

If there is a discrepancy, you are still responsible for the balance. Understand that before you receive a statement, we have made EVERY EFFORT to get your insurance company to pay what was estimated.

Unpaid balances after 90 days will be charged an interest of 12% for every month the balance is unpaid. We offer Care Credit and Compassionate Financing to help you with any out of pocket expenses or unpaid balances. Both options offer low interest financing. We would be happy to go over that with you if you have any questions.

Our Policy on No Show or Missed Appointments

We value your time and reserve this appointment time just for you. We take pride in running on schedule and giving patients our undivided attention. We understand personal emergencies occur and always take that into consideration. A change in your schedule not only affects your health, it also affects the schedules of many other people.

If you find that you cannot commit to your reserved appointment, we ask you provide a minimum cancellation notice of 24 hours. Failure to do so will result in a minimum missed appointment fee of $75.

I have thoroughly read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as all applicable co-payments and deductibles are my responsibility!

I authorize Dr. Gina Maestri to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Print Patient's Name: _____

Signature of patient or responsible party: _____ Date: _____