Kids and Family Dentistry | Dr. Farideh Golestani & Associates
471 West Mt. Pleasant Avenue | Livingston, New Jersey 07039
Telephone 973-597-1818 | Fax 973-597-1817

FINANCIAL POLICY

1. Payments are required in full at the time of the treatment unless other arrangements are made prior to services rendered.
2. If the patient has insurance, this office, as a courtesy to you, will submit the claim to the insurance, but it is the patient's responsibility to insure that the bill is paid in full.
3. There is a fee of $75 for any "missed" appointment. The appointment is considered missed if the cancellation was received less than 48 hours before the appointment is scheduled or the patient is late for more than 30 minutes of the visit.

   Driver's License#: _____ State: _____ SS#: _____

   Credit Card: _____ Exp: _____ / _____ CVV: _____
4. This credit card will be used to reserve all appointments scheduled and all other fees for services. Each appointment is reserved exclusively for you. There is a cancellation fee for appointments not cancelled with a 48 hour notice.
5. There will be a charge of $50 fee for each check returned due to insufficient funds.
6. Any balance past due for more than 30 days is subject to finance charges at the rate of 18% annually that will be paid to the office.
7. In the event that my account becomes delinquent for more than 31 days, I also agree to pay a finance charge of 1.5% 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.
8. All charges are the patient's responsibility regardless of any insurance company payments. Not all services are a covered benefit in all plans. IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR DENTAL BENEFITS.

I hereby agree to the above terms.

Patient Name: _____ Date: _____

Signature: _____
(Parent or Guardian signature for minors)