Joseph I. Frontera, D.D.S.
101 West Ridgely Road, Suite 3B
Lutherville, Maryland 21093
(410) 252-1900

Office Guidelines and Financial Policy

Thank you for selecting us as your dental health care practitioner. We are committed to your dental health and we need your understanding and cooperation with respect to our financial policy and your financial obligations.

*****Please read and sign before being seen.*****

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment Options

Payment is due at the time of service, regardless of insurance benefits. For your convenience payment options include:

Cash, check or any major credit card
Extended payment plan (with prior credit approval) through:
Wells Fargo or Unicorn

Returned Check Fee

There will be a $25.00 fee applied to your account for any checks that are returned for insufficient funds.

Dental Insurance

Patients with dental insurance are required to pay their **Deductible and Estimated Portion** of our fees at the time treatment is rendered. We will accept assignment of insurance benefits. However, we do require a 30 – 50% (based on insurance co-payment) of the bill to be paid at time of service. A refund check will be mailed to you if an insurance carrier pays more than we estimated.
By signing below I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the office of Joseph I Frontera DDS, PA

While filing the insurance is a **service we extend to our patients**, we must emphasize that as dental providers, **our relationship is with our patients,** not the insurance company. If a full payment is not received from your insurance carrier within 60 days, the balance becomes your responsibility and will be subject to a finance charge of 1.5% interest per month, and also may be subject to a billing charge. To avoid this fee please authorize us to transfer this balance to your credit card.

Discover/ Visa/ MasterCard Number: _____ Expires: _____

Signature: _____

We **Can Not** file secondary dental claims. However, we will give you a computer generated Insurance Claim, with all necessary codes and procedures, which you can submit to your secondary insurance carrier.

Minor Patients

Must be accompanied by a parent or guardian for all appointments. The adult accompanying the minor is responsible for the full payment the day treatment is rendered.

Missed Appointments

Your appointment time has been **scheduled at your request.** If this time becomes inconvenient for you, please notify our office within 48 hours notice before that scheduled time or a **minimum fee of $35 per half-hour** will be charged. It is **not our intention to charge you**, however we do require this notification to offer this time to another patient. **Please help us avoid charging a fee** by keeping your scheduled appointment.

I have read the above policies and agree to abide by them.

Signed: _____ Date_____
(Patient, Parents or Guardian of Minor)