DR. FUZY & ASSOCIATES FINANCIAL GUIDELINES

1 - Pay As You Go

Our “Pay as you go” option allows you to be in control of your insurance benefits, by paying fully at each appointment for treatment and by being reimbursed directly by your insurance company. This will enable you to keep personal records of all insurance reimbursements, all dental transactions, to track maximum allowable benefits and be more aware of what your plan covers and what it does not cover. You will never have to worry about having outstanding account balances with us. We will make sure your insurance claims will still be filed, and that payment will go directly to you.

When insurance companies reimburse patients, payment usually takes about one to two weeks to be received, especially if the patient’s plan accepts electronic dental claims. If required, at each appointment we will send electronic claims for you.

2 - Assignment of Benefits

Our “Assignment of Benefits” option offers you the convenience of using your dental benefits as a form of direct payment by assigning payment from your dental insurance company directly to Dr. Fuzy & Associates. Please be reminded that your dental insurance is an agreement between your insurance company and you. This means you are responsible for any service fees or balances that may not be covered by your dental benefits plan. Choosing Dr. Fuzy & Associates to submit electronic claims on your behalf requires you to leave a valid credit card number on file (Visa, Mastercard or American Express) as a precondition. Balances not covered by your dental insurance will be charged directly to your credit card on the day of the treatment, or by the day the cheque is posted to your account. If you decline leaving your credit card on file, you miss the courtesy of Dr. Fuzy & Associates accepting direct payments from your insurance company on your behalf and you will be responsible for the payment in full at the end of each appointment. Please fill out and complete the credit card authorization form below. It will be kept strictly confidential and will be used only under the agreed terms.

3 - Low Interest Financing

Our “Low Interest Financing” option offers you an arrangement with our financial partner (Credit Medical Corporation). Upon approval, you can receive a low-interest term loan (from 6 months to 4 years) with low monthly payments, a fixed interest rate, and no down payment or collateral. Please inform us if you require an application.

4 - Quick Check-Out

Or “Express Checkout” option allows you the convenience of coming in for treatment without having to check out after the completion of your appointment. We will still submit claims to your insurance company and your insurance company will directly reimburse you. All there is to do is fill out our credit card authorization form below. It will be kept confidential and used strictly under the agreed terms. We will bill your credit card after each appointment and a receipt of this transaction will be mailed to you.

5 - 5% Reduction for Prepayment in Full

In order to fit expenses into their monthly budgets, some patients prefer to have their treatment completed in “phases,” or stages. By "phasing" their treatments, patients will not need to make compromises with regard to the quality of the care they receive. Planning and treatments will work according to your schedule – when you can pay and according to your budget.

BROKEN APPOINTMENTS: A specific frame of time is reserved especially for you and we strongly encourage patients to keep their appointments. If you have to change your appointment, we require at least 48 hours notice to avoid charging you with the $100.00/hour cancellation fee.

_____
PRINT NAME

_____
SIGNATURE

_____
DATE

Credit Card Authorization Form

I _____ hearby authorize Dr. Fuzy & Associates to submit electronic claims on my behalf and agree to assign the payment directly to Dr. Fuzy & Associates. I understand that my insurance is an agreement between the insurance company and myself. I further understand that I am responsible for any service frees or balances that may not be covered by my dental benefits plan and any differences resulting from the amount billed and the amount covered by my plan.

Signature: _____

Date: _____

Patient Name: _____

Phone #:_____

3rd Party Payment: _____

(responsible party name)
Please circle credit card: Visa MasterCard

Card #: _____

Expiration Date: _____

Card holder signature: _____

CC security code: _____

Print name: _____

Date: _____

Staff Initials: _____