



# DR DOMENIC SAVO SARDARO DENTISTRY

## FINANCIAL AGREEMENT

Patient:

Parent/Guardian of Patient:

**Please initial one of the following financial policies pertaining to yourself and/or dependants.**

**1. I do not have any insurance benefits**

I am aware that I am responsible for the entire fee on the day treatment is rendered, unless written financial arrangements have been made. *(Please see below for payment methods)*

**2. I have dental benefits through my employer/self plan that allows \*assignment\***

I am aware that prior to Dr. Domenic Savo Sardaro accepting *assignment\** from my plan, I am responsible for the provision of my booklet of benefits/rundown of my plan and student I.D. for any dependants under my plan (if applicable). I am also aware that I am responsible for any portion of the fee not covered under my plan (i.e. deductible, co-payment, difference in fee guide.) on the day treatment is rendered. In addition, *if my claim is not paid from my Insurance Company 30 days after treatment, I am responsible for the full treatment fee\*\**. I am aware that Dr. Domenic Savo Sardaro Dentistry will send my claim on my behalf and am responsible to sign a claim form at each appointment. If claims can be sent electronically, I am required to await receipt of the submission verification report, prior to leaving the dental office at the end of my appointment. *(Please see below for payment methods).*

**3. I have dental benefits through my employer that does not allow \*assignment\***

I am aware that I am responsible for the full cost of treatment on the date treatment is rendered. Please note a 30 day post-dated cheque is allowed for non-assignment patients. *(Please see below for other payment methods).*

**4. I am covered by GWA (Social Assistance)**

I am aware that I am responsible to present my current month cheque stub (or copy), which verifies my case I.D. on the day of treatment (i.e. where the treatment date is March 4, 2009, we require your March 2009 cheque stub). *Otherwise I am responsible to pay in full on the day of treatment.* I am also aware *GWA will reimburse only for emergency dental treatment as per their own fee guide.* I am aware that I must sign a claim for at each appointment for treatment rendered.

**5. I am covered by ODSP (Ontario Disability Support Program)**

I am aware that I am responsible to present my dental benefits card (current month) on the day of my appointment, *prior to my treatment*, otherwise I am responsible to pay in full on the day of treatment. *(Note: if your appointment is scheduled for April 7, 2009, we require the April 2009 dental card).* I am aware that ODSP will reimburse within the limitations of their own fee guide. I am aware that I am responsible to sign a claim form at each appointment for treatment rendered.

**6. I am covered by NIHB (Indian Status)**

I am aware that I am required to present original identification card in order for a copy to be retained in my file. I am responsible to sign a form specifically for NIHB at each appointment for treatment rendered. I am aware NIHB will reimburse within the limitations of their own fee guide.

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**\*Assignment:** Assignment of insurance is when the patient signs a section of the insurance forms which allows the dentist to receive the treatment fee directly from the insurance companies (Please note that this dental office accepts assignment (if your plan permits) as a courtesy to you)

**\*\* Patients can prevent being responsible for the full fee after 30 days of treatment by enquiring with staff of Dr. Domenic Savo Sardaro Dentistry, if payment has been made and received by the 3<sup>rd</sup> week, after treatment. If claim has not been paid, the dental staff will attempt to contact your Benefits Administration to enquire on the status of your claim (if permissible). We will notify you if your administrator requires the benefits recipient (you) to personally enquire with your plan. If your claim has not been received by your Benefits Administration and/or requires additional information from you, you must ensure you submit such prior to the 30-day period (i.e. resubmission (with signature), student I.D, etc.).**

**Payment Methods:** Cash, Visa, MasterCard, Personal Cheque (with identification), Interac.

You are responsible to pay any expenses occurred due to NSF cheques.

I, \_\_\_\_\_ have read and agree to the terms mentioned above in regards to the treatment fee for myself and/or family members (if applicable): \_\_\_\_\_

\_\_\_\_\_

Signature

\_\_\_\_\_

Date