# Statement of Financial Policy

***Welcome to the office of Dr. Alan Reisman, DDS. Our intent is to provide you with the best oral surgery care at the most reasonable cost possible.***

1. **Patients with dental insurance** are asked to pay their estimated co-payment at the time of service. Please be advised that we can only estimate the amount that an insurance company will pay. We strive to maximize dental benefits: however, the patient is ultimately responsible for the balance. We accept cash, check, Mastercard, Visa, American Express and Discover.
    a. Those patients unable to meet their complete financial obligation on the date of service may make special arrangements in advance.
    b. A pre-determination of benefits can be sent at the patient's request.
    c. Any unpaid insurance balance, beyond 90 days from the filing date, is the full responsibility of the patient.

2. **Patients who do not have dental insurance** are asked to make payment in full for services on the date of service. We accept cash, check, Mastercard, Visa, American Express and Discover.
    a. Those patients unable to meet their complete financial obligation on the day of service may make special arrangements in advance.

***** Patients are responsible for treatment cost not covered by insurance, along with any incurred collections and/or attorney fees.

Please sign below indicating tht you have read the above statements and accept the financial policy of Dr. Alan Reisman, DDS.

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Patient or Guardian Date