Dr. Vicki Hui Zhu
Family and Cosmetic Dentistry
6 Essex Center Drive, Ste. 204
Peabody, MA 01960
(978) 531-8911

FINANCIAL POLICY AGREEMENT

We are dedicated to provide the best possible patient care, and we want you to completely understand our financial policies.

Patient with Insurance

If you have insurance we will gladly file your claim. Deductibles and co-pays are expected **PRIOR** to service being rendered. We can only estimate the amount you owe, which is based on the information you insurance carrier provide us. If your insurance carrier pays less than their estimated portion, you will be responsible for the remaining balance upon receiving your bill.

Patients with no Insurance

Full payment is expected on the day of service.

Treatment Plans

Treatment plans are based upon an estimated calculation. It may be necessary to do additional treatments, which will result in a change of fees and the amount you owe.

Composite Restorations

We provide composite (white filling) restorations. Your insurance carrier may only pay for amalgam (silver) restorations, therefore you are responsible for the amount not covered by your insurance carrier and this amount is due at the time of service.

Broken Appointments

We reserve the right to charge $25.00 for appointments cancelled or broken **without 24 hours notice**. This charge must be paid before another appointment can be scheduled. Arriving 15 minutes or more after your scheduled appointment could result in rescheduling your appointment and a broken appointment charge. **2 MISSED APPOINTMENT** occurrences will result in discharge from our practice.

Payment Plan Option

We accept Springstone and Care Credit®. See front desk if you have further questions.

Assignment and Release of Information

I assign the benefits from my insurance carrier to Vicki H. Zhu D.M.D for the dental benefits I am entitled for any services furnished to me. I authorize Vicki H. Zhu D.M.D to release to my insurance carrier any information needed to determine benefits for my care.

Authorization

I have read and agree to be bound by the financial policy's terms stated in the paragraphs above and accept full financial responsibility for the fees charged. I also understand and agree that such terms may be amended from time to time.

Please print the name of the patient: ____________________________ Date: ___________________

Signature of patient (or responsible party, if patient is a minor or has legal guardian):_____________________________