Financial Policy and Agreement

Thank you for choosing Sparta Smiles Synergy, the office of Dr. Anar Naik, for your dental care. Our office philosophy is to work as a team to provide our patients with the highest quality of dental care possible with professionalism, compassion and open communication. Therefore, we would like to provide a clear statement of our financial policy here.

Please provide us with the most accurate and current information regarding your dental insurance coverage, or alternative financial information if you do not have insurance. Notify us prior to your appointment if there are any changes to your financial information.

Payments are due at the time of service. For every treatment plan discussed and agreed upon between the dentist and the patient, we will provide you with a breakdown of your total financial responsibility prior to the treatment. If the treatment requires multiple appointments, the payment can be divided over the total number of visits.

For any procedures that require a pre-determination by insurance, you will be notified of the patient responsibility after pre-authorization is received from your insurance carrier. You will be responsible for any insurance co-payments, deductibles and fees not covered by your insurance.

If payment is not received at the time of service, you will receive a bill for the outstanding balance. Please note, there is a 1.5% finance charge applied to all accounts overdue past 60 days that will accrue monthly. We do offer the flexibility of setting up payment plans in order to help accommodate your present financial situation, please bring this to our attention if you would like to do so.

Accepted payment methods include the following: Check, cash, credit card (Visa, MasterCard, Discover, AmericanExpress), debit card (including HSA and FSA). For credit card transactions, there will be an applicable 2.5% surcharge.

I, _____, the undersigned, acknowledge that I have reviewed,
(Name of Patient or Parent/Guardian)

understood and agree to the financial policy of the office.

Signature: X _____ Date: _____

We thank you for your understanding and cooperation, and we look forward to working as a team to achieve your dental needs.