John F. Como D.D.S., P.C. 140 Lockwood Avenue, Suite 209 New Rochelle, NY 10801

Financial Agreement & Cancellation Policy

The following explains our financial agreement and our policy regarding cancellations while you are under the care of John F. Como, D.D.S., P.C.

Financial Agreement

- ***Payment is due in full on the day of your appointment*** *unless other arrangements have been made prior to treatment.*

- ***We accept the following forms of payment:***
  - *Personal checks (A minimum fee of $25 will be charged in the event of non-sufficient funds (NSF) per occurrence)*
  - *Credit/Debit Cards (MasterCard, Visa, Amex & Discover)*
  - *Cash*

- ***For our patients with dental insurance:***
  - *John F. Como, D.D.S., P.C. is an out-of-network dental provider, meaning he does not participate in any dental insurance networks, Medicare, Medicaid, or dental discount plans.*
  - *We are happy to help with your claim submissions to your insurance carrier in the event you have insurance benefits available.*
  - *Your insurance carrier is responsible for reimbursing you for services based on your enrolled dental benefits package.*
  - *All fees are the direct obligation of the patient. It is the patient's responsibility to verify coverage and requirements with their dental insurance carrier.*
  - *Should your insurance carrier request additional information/x-rays to process your claim submission, please contact us.*

JOHN F COMO
DDS/PC

Cancellation Policy

We ask that you please arrive on time for your scheduled appointment and if you are running late, please call the office at 914-632-1111. Likewise, we understand that occasionally circumstances arise necessitating cancellation.

No-shows & cancellations of less than 2 business days' notice will incur a missed appointment/cancellation fee. We are unable to make exceptions to this policy.

*Patients scheduled with our **Hygienists**:*

*A **$100.00** missed appointment/cancellation fee will apply per occurrence.*

*Patients scheduled with **Dr. Como**:*

*A **$200.00** minimum missed appointment/cancellation fee will apply per occurrence.*

By signing this Financial Agreement & Cancellation Policy, you are indicating that you understand and agree to the terms of service outlined. Thank you for your cooperation.

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Signature of Patient or Legal Guardian

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Print Patient Name

_____

Date


JOHN F COMO
DDS/PC