General Dentist
Dr. Marjan Fakhri

Billerica Professional Building
337 Boston Rd
Billerica MA 01821
(978) 663-3321

FINANCIAL POLICY AGREEMENT

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy Agreement which we require that you read and sign prior to your treatment.
It is our policy that all outstanding balances are paid in full. Co-pays, deductibles, co-insurance as well as non-covered services are your responsibility.
WE ACCEPT CASH, CARE CREDIT, AND MOST MAJOR CREDIT CARDS.

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. However, as a courtesy to our patients, we will file your primary insurance claims for you. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services.
We understand insurance guidelines can be difficult to understand and overwhelming at times. Fortunately, with the information provided to us by your insurance company we are able to provide some assistance in estimating your insurance benefits. However, your insurance company makes final determination once treatment is completed and the claim is submitted.
All deductibles and co-payments are due the day the treatment is rendered.

Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim. **REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL.** Once a payment is received on your claim, we will send you a bill for any remaining balance on your account.
All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.
Thank you for understanding our Financial Policy Agreement. Please let us know if you have questions or concerns.

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I have read the Financial Policy Agreement. I understand and agree to this Financial Policy Agreement.

Patient or Parent/Legal Guardian Name (Please Print)

Signature of patient or Parent/Legal Guardian
Date