FAMILY, IMPLANT & COSMETIC DENTISTRY

Fadi G. Raffoul, D.M.D.
Sanford N. Schwartz, D.D.S.

Our Philosophy:

To provide the very best dental care available while treating all patients as members of our family.

Our Mission:

To preserve, restore and replace teeth; to enhance smiles, improve dental health and overall health. By doing so we will improve quality of life and length of life for our patients, our families and ourselves.

OAK PARK PLAZA
787 WEST LUMSDEN RD.
BRANDON, FL 33511-6261

813-684-7888
813-684-4568 – FAX
info@implantandcosmeticdentistry.com
www.ImplantandCosmeticDentistry.com

FINANCIAL POLICY AGREEMENT

Concerning Your Dental Benefits:
Dental insurance is a contract between you and the insurance company. Despite our efforts, there is no guarantee of benefits or reimbursement. As a courtesy, we will bill your insurance company on your behalf. If your insurance company has not made payment within 30 days, the outstanding balance becomes your responsibility. Please remember the insurance agreement is between you and the insurance company.

Insurance co-payment and/or a deductible payment is the patient's responsibility. We verify insurance benefits as a courtesy to you. This is not a guarantee of payment from your insurance company. It is possible your balance will be different than our estimate.

I fully understand and agree that my financial arrangements and obligations with Family, Implant & Cosmetic Dentistry supersede any and all insurance contracts that either I or the office may have signed. The office may accept an "estimated co-payment" initially, but the PATIENT IS ULTIMATELY RESPONSIBLE FOR THE ENTIRE FEE.

Concerning Your Appointments:
We try to confirm appointments with a telephone call in advance as a reminder. Please return these calls to hold your appointment day and time.

Guaranty of Payment:
By signing below, I accept personal responsibility for the payment in full of my account.

Other Billing Information
If you receive a bill in error, call our office to clarify your obligation. Returned checks or "insufficient funds" will be charged $35 per check.

_____ _____

Date Signature