

**PRINCETON PARK DENTAL ASSOCIATES, P.A.**  
**OFFICE FINANCIAL POLICY**

The financial policy of Princeton Park Dental Associates is that payment is expected at the time service is rendered. We accept cash, check (with appropriate identification), MasterCard, Visa, and American Express.

Princeton Park Dental Associates offers to its patients (from an outside credit company) an opportunity to apply for an interest free credit card which can be used when paying for your dental needs (pending credit approval). If that is of interest to you, please feel free to discuss it with our front desk personnel.

As we reserve time in our schedule especially for you, we feel it is important that you keep your scheduled appointments. Therefore, it is our office policy to charge patients a \$75 per half hour broken appointment fee. This fee is assessed for all appointments, which are not cancelled or rescheduled at least 24 hours in advance.

**OUR POLICY ON DENTAL INSURANCE**

Dental insurance is one of the most beneficial and most misunderstood factors in dental treatment today. This explanation will attempt to clear up many common misconceptions about dental insurance.

Dental insurance is a contract between the employer, the patient and the insurance company. It has NO CONNECTION at all to the provider of dental treatment. (i.e., the dentist). The extent of coverage varies greatly from company to company, and sometimes even within a company. It has absolutely nothing to do with the level of service provided by the dentist and the fee charged for these services.

An often-misleading term used by many insurance companies is "UCR." This is an arbitrary fee ceiling at which the insurance company will stop reimbursement. After this ceiling, coverage for a particular procedure will cease. Again, this has nothing to do with the fee charged, but with the level of coverage negotiated by your employer.

If you have any further questions concerning dental insurance, please call the office and we will be happy to assist you.

**PATIENT SIGNATURE**

*I have read the above policy in its entirety. I understand that payment is expected when treatment is performed. I understand that I am financially responsible for the above named person regardless of insurance participation.*

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Signature of Responsible Person

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Date