Joshua M. Greenberg, D.M.D., P.C.

Practice limited to Periodontics & Dental Implants

99 November Drive, Suite 301
Camp Hill, PA 17011
(717)737-2555

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive periodontal care using only the highest quality materials and technology available on the market today. All charges you incur for any treatment provided are your responsibility regardless of your insurance coverage. We will always recommend treatment based upon your periodontal needs, not based on your insurance coverage, which can be inadequate with some dental plans. We do require that the ***estimated*** co-payment for treatment be paid at the time of service. This is the portion of our fees that your insurance coverage does not assist you with.

Your ***estimated*** co-payment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard and Visa. Third party extended financing is also available upon request and approval. Returned checks and balances older than 60 days will be subjected to collection fees and finance charges at the rate of 1.5% per month (18% annually).

We will accept an assignment of benefits from your insurance company but it is important to understand that the agreement regarding your dental benefits is a contract between you, your employer, and your insurance company. As a courtesy, we will submit dental claims on your behalf. However, we do not accept responsibility for the outcome of the transaction.

Insurance payments are usually received within 30-60 business days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time and you will then be responsible for seeking reimbursement from your insurance company.

We do not guarantee payment from your insurance company. If your claim is denied, for any reason, you will be responsible for paying the full amount at that time. We will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. It is your responsibility to resolve any type of dispute over payments made or not made by your insurance company to us.

Cancellations and Rescheduling Dental Visits

Our office does require 24 business hours notice to cancel/reschedule existing visits with us. We reserve the right to impose a missed appointment fee of $75.00.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THE FINANCIAL AGREEMENT AND I AUTHORIZE MY INSURANCE COMPANY TO PAY ALL MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE OF JOSHUA M. GREENBERG, D.M.D., PC.

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Print Name of Patient or Responsible Party

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Signature of Patient or Responsible Party Date