William F. Jones, D.M.D.

720 Route 202-206 North
Bridgewater, NJ 08807

908-725-3377
www.drwjones.com

Financial Policies

We are committed to providing you with the best possible care. If you have dental insurance, we are happy to assist you to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, and Visa. We will also gladly assist you in filing your insurance claim.

Returned checks and balances older than 60 days are subject to interest charges of 1½ % per month with an annual rate of 18%, in addition to any collection agency fees and/or attorney fees and court costs incurred in the collection of outstanding balance.

Appointments broken or cancelled without 24 hours advance notice are charged $50 for every 30 minutes of the scheduled appointment time.

Upon request, we will gladly discuss your proposed treatment and give an estimate of all charges for any procedure. Our office will also be happy to answer any questions relating to your insurance.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named of the insurance benefits otherwise payable to me.

_____ _____

Signature (Parent if patient is a minor) Date