Hudson View Dental
Ruba F. Rizqalla, DDS

105 Shad Row, Ste 1A
Piermont, NY 10968
Tele: (845) 359-6315 Fax: (845) 359-4788

FINANCIAL POLICY

In our continued commitment to provide the highest quality dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment.

Please check one of the following:

[ ] **PERSONAL CREDIT CARDS**	[ ] **PREPAYMENT**
[ ] VISA [ ] Discover [ ] MasterCard [ ] American Express	We are happy to offer a 5% discount for services over $1,000.00 when prepaid in full upon scheduling your appointment.

We are pleased to offer two financing options which are administered for us by

[ ] CARE CREDIT

Please ask our administrative staff for details and credit applications

We are committed to support you in understanding your ocular health, so that you will always be able to make the best choices.	We will, as a courtesy, process your insurance benefits in our office, which will relieve you of this time consuming and sometimes-complicated task.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due and payable at the time services are rendered, regardless of whether or not my insurance benefits have been received. One and one-half percent (1.5%) per month interest (18% per year) will be charged on accounts 60 days from treatment date.

MISSED APPOINTMENTS

Appointment times are reserved especially for you. If you come in late, the Doctor may request that you reschedule the appointment and you may be charged a fee of $75. If for any reason you should need to change your appointment, there will be no charge, provided you give us 48-hour notice. Please help us serve you better by keeping your scheduled appointments. We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.

Patient Signature (Responsible Party): _____

Patient Print Name (Responsible Party): _____

Financial Coordinator (initials): _____

Date: _____