Denise Cohen-Kronfeld, D.M.D., PLLC
1315A Broadway
Hewlett, NY 11557

Office Financial Policy

In developing treatment plans for our patients we are guided by the current standard of care within the dental profession and by our own high standards of ethics and moral responsibilities to our patients. Our responsibility is to provide you with the highest quality of care, using the latest concepts and techniques in a clean, safe environment. In order to achieve this goal, we need your assistance and complete understanding of our financial policy. You are ultimately financially responsible for the professional services provided.

FULL PAYMENT FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

For your convenience, we accept cash, checks, and all major credit and debit cards.

Insurance

Our office is committed to helping you maximize your insurance benefits. Dental insurance is meant to be an aid in receiving dental care, and does not always cover the full cost of treatment. Because insurance policies vary, we can only estimate your coverage in good faith but *cannot* guarantee coverage due to the complexities of insurance contracts. Your estimated patient portion must be paid at the time of service. As a service to our patients, we will bill insurance companies for you.

Cancellations

Your scheduled appointment time has been reserved specifically for you. We request 48-hours notice if you need to cancel your appointment. A charge of $50 is assessed for each "no show" or appointment cancelled with less than 48-hours notice.

Returned Checks

Checks returned from your bank unpaid are subject to a $35.00 processing charge

Outstanding Bills

Balances that are beyond 30 days past due are subject to a $10.00 monthly fee, unless other arrangements have been made in advance

Payment Plans

As a courtesy, we offer payment plans for families who need financial assistance. Your credit card will be charged the amount agreed upon by you and our office on the mutually agreed upon date.
Delinquent payment plans will be charged a $50 per month fee.

I have read and understand the above financial policy and agree to abide by it.

Patient/Legal Guardian_____Date_____