John J. Tortora, D.D.S, LLC
Victoria Welsh, D.M.D
2095 Highway 88 | Brick NJ, 08724 | (732) 295-1616

AN OVERVIEW OF OUR FINANCIAL POLICY

Thank you for choosing John J. Tortora, D.D.S., LLC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible. We offer several **payment options** which include:

- Cash, Check, Debit cards, Visa, MasterCard, American Express or Discover Card

- NO INTEREST[1] Payment Plans[2] from Care Credit with no annual fees or pre-payment penalties.

Please note:

We accept most insurance, but we DO NOT participate in every dental insurance policy. We require our patients with dental insurance to make a payment of 20% at time of treatment for all services, unless the services are covered at 100%. As a courtesy, we will file dental claims with your insurance carrier and process insurance payments, [3] but **ULTIMATELY, IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS AND COVERAGE.** If you are unsure if you are eligible for services or have insurance money remaining, please ask for a pre-authorization to be submitted to your insurance carrier at least 4-6 weeks prior to your scheduled appointment.

For Patients without insurance, payment in full is required at time of treatment unless prior payment arrangements have been made with the office manager.

Broken or cancelled appointments *are subject to a fee of up to* ***$75.00*** *without 24-hour notice.*

Past Due accounts over 60 days are subject to a $16 billing fee to cover the cost of extending supply and postage. There will be a **$40.00** bank fee for all returned checks and all accounts over 90 days are subject to a monthly interest fee of **1.5% APR.** Accounts over 120 days are subject to be filed in court or with an attorney. ***All court fees and attorney costs, plus an additional 18% interest fee will be added to your current balance and will be the patients' responsibility***. If you have any questions regarding this policy statement please ask our office manager before signing. We are here to help you determine the best payment options for the dentistry you want or need. **By signing this you are acknowledging our policy and stating that you understand it in its entirety.**

_____
Signature of Party Responsible for Payment Date

_____
Print Name of Responsible for Payment if other than the patient

_____
Print Patient Name

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees in full and collection of your benefits directly from your insurance carrier.