

**FINANCIAL AND CANCELLATION  
OFFICE POLICIES**

Willam E. Zugner, D.D.S., Todd R. Pedersen, D.D.S., P.L.L.C.  
55 North Ave., Webster, NY 14580

Our Policies have been set up to prevent misunderstandings. Please initial below each policy. If you have any questions regarding the below information, please contact the office.

**Financial Policy:**

We accept cash, checks, all major credit cards and offer Cherry Financing & CareCredit.

1. Payment is expected in full at the time of service unless other arrangements have been made.
2. A service fee of 2.0% per month will be applied towards unpaid balances after 90 days.
3. Returned checks are subject to a \$25 service charge.
4. Failure to communicate an overdue balance may result in your account being turned over to a collection agency. The patient is responsible for all fees/costs associated with the collection process.

**Initial:** \_\_\_\_\_

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**Insurance:**

We participate with Excellus BCBS, Cigna PPO, and UNUM dental insurance.

Your dental insurance contract is an agreement between you and your insurance company. We will process all insurance claims as a courtesy, but the patient or guardian is responsible for understanding their dental insurance eligibility and benefits. We recommend asking for a predetermination of benefits prior to any basic/major dental work. This is only submitted upon the patient's request and we cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed.

**\*Any remaining balance after your insurance has paid is your responsibility.\***

**Initial:** \_\_\_\_\_

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**Cancellation Policy:**

Failure to provide 24hr notice of cancellation may result in a charge. This fee must be paid prior to rescheduling your appointment.

- A. \$50 per hygiene appointment
- B. \$75 per ½ hour with the doctor

**\*If you are more than 15min late, your appointment will automatically be marked as missed and will need to be rescheduled.**

**THE DOCTORS RESERVE THE RIGHT TO DISMISS YOU FROM OUR PRACTICE AFTER 3 OR MORE MISSED/CANCELLED APPOINTMENTS**

**Initial:** \_\_\_\_\_

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**Please print and sign below to indicate that you have read and fully understand the above policies:**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS FORM AFTER YOU SIGN IT.**