Drs. Scannell And Hollinger, Inc.
79 Maple Street, East Longmeadow, MA 01028
413-525-6821

## Financial Policy

Our office is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees and our financial policy.
Patients must complete all information forms prior to seeing the dentist or hygienist. A copy of your insurance card will be retained in your electronic file. If your insurance changes it is your responsibility to notify our dental office of that change.

## Payments

Co-Payments: By law, we must collect your carrier-designated co-payment at the time of service. Please be prepared to pay that co-payment at each visit.

Non-Copayment Plans: If your plan does not require a co-payment and we participate, we will accept the designated fee. You are responsible for any deductable and balance your plan indicates on their explanation of benefits.

Self-Pay: Payment is expected at time of service.

Account Balances: You are responsible for the timely payment on your account. Please call the office and speak to the Office Manager for payment plans if you are in a financial hardship.

## Return Check Policy & Fee

We accept local checks. There is a $25.00 fee for any checks that are returned.

## Dental Insurance

As a courtesy to our patients, we will file your dental claims and accept assignment of benefits from participating insurance providers. In order for us to be able to provide this service, please provide us with all accurate and current dental insurance information. Your employer has arranged the contract between you, your insurance company and your employer. We are not a party to this contract. Ultimately, any balances you have remaining for services is your responsibility.

## Discontinued Treatment

If for any reason you choose to discontinue treatment that includes lab fees the total lab fee will be owed.

**Our Office Accepts:** Cash ▪ Check ▪ Visa ▪ Mastercard ▪ Discover ▪ American Express ▪ Care Credit

**Signature of Responsible Party:** _____ **Date:** _____

**Printed Name:** _____**Date:** _____