



## Fees & Policies

### Insurance

Dental insurance is intended to cover some, but not all of the cost of your dental care. Most plans include coinsurance provisions, a deductible, and certain other expenses, which must be paid by the patient at the time of services. Reimbursement amounts are not, and have never been, a guideline for quality care.

We accept many insurances and as a courtesy we can file most claims for you. **However, it is your responsibility to know and understand your dental benefits.** We will work to ensure that you receive the maximum benefits to which you are entitled. Please bring your insurance card with you on your first visit. You must notify our office if your insurance plan changes prior to appointments.

### Financial Policy

If your dental insurance permits assignment of payment, we will bill your dental insurance provider. We will estimate our deductible and co-pay, which are **payable on the day services are rendered.** If assignment of payment is not permitted, payment for all services rendered are due on the day of treatment, we will still submit a claim to your insurance. Most dental insurances will send you an Explanation of Benefits (EOB), explaining payments made to the dentist, or reason for denial of any claim. It is imperative that you review any communication from your insurance company, as the EOB determines actions that may need to be performed by the member prior to a claim being settled. **Submitted claims that have not been processed for payment by your dental insurance 45 days from the date of rendered services will become your financial responsibility and a statement will be mailed.** Your dental plan benefits are a contract between the member/employer and the Dental Insurance Provider. **Again, it is your responsibility to know your dental plan.** If you have any questions regarding your dental plan benefits or EOB, please contact your Dental Plan Provider.

### Treatment Plan Estimates

Our staff provides an estimation of planned services. Please keep in mind that this is **only an estimation** based on provided benefits and is not a guarantee of payment from insurance. **If insurance pays less than anticipated, you will be responsible for all additional fees.**

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**Co-payments**

For portions of cost not covered by insurance, we offer these payment options: cash, personal check, most major credit cards, debit cards, and Care Credit. Please ask our staff about your Care Credit options.

**Cancellations and Appointment Changes**

Your appointment is reserved just for you. We respect your time and make every effort to stay on schedule. If you must reschedule your appointment, we request at least **24 hours notice** so that your reserved time may be given to another patient in need of dental care. We reserve the right to cancel, change, or move any appointment at any time. We will do our best to inform you of any and all changes. Any patient arriving more than 15 minutes late to any appointment is not guaranteed to be seen. Consecutively missed appointments may result in a dismissal from the practice.

**Uninsured Patients**

We require full payment at the time services are rendered unless other arrangements have been made with our office manager. Please consider signing up for our dental discount plan. This is NOT insurance, but rather a discount plan offered in-house in order to help our patients afford necessary treatment and receive regular dental care.

**Parental Responsibility**

Divorced or separated parents will be required to work out all financial arrangements. The parent bringing the child to the appointment will be responsible for all payment needed on that day of service.

**Returned Checks**

All returned checks will incur a \$40.00 handling fee.

**Finance Charge**

15% APR may be added to all accounts not paid in full within 45 days of completion of treatment or account due date. If the account becomes past due the patient will be responsible for collection costs or attorney fees that will be needed to collect the past due accounts.

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**Patient Name [Print]**

**Date**

**Signature of Patient**

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