ALBION DENTAL CARE
Ammar F. Farra D.M.D. P.C.
6 Albion St., Wakefield, MA 01880
(781) 245-1955
23C Cambridge St., Burlington, MA 01801
(781) 229-1955

Welcome and thank you for choosing our office for your dental care.

Financial Information:

Albion Dental Care accepts most insurance for your convenience. Our office is happy to help you file your insurance claims to receive dental benefits. We work hand in hand with you to maximize your insurance benefits for covered procedures. If you have any questions regarding your dental insurance, please ask our staff.

Before any treatment is performed, you will receive an estimate of the anticipated charges. **Payment of co-pays and any uninsured portion of any fee is due at the time that treatment is performed.** Our staff will attempt to estimate the amount of insurance coverage however this is only an estimate based upon the best information we can obtain from your insurance carrier. Therefore, the amount due after insurance payment may vary from the estimate. For your convenience we accept all major credit cards – Amex, Visa, MasterCard and Discover. For patients **without dental insurance** you may make arrangements with Care Credit for a monthly payment plan.

We reserve the right to charge a $25.00 missed appointment fee if 24 hours notice has not been given. Original x-rays are the property of this office. If you wish to have your x-rays duplicated there will be a $25.00 fee for this service. Copies of your dental chart are free of charge.

I understand that my account is my financial and legal responsibility and that balances must be paid within 90 days or may be assessed a finance charge of 1.5% per month, 18% annually. I understand that defaulting on my account will result in serious consequences, which may include being forwarded to a collection agency. I understand that I will be responsible for all collection and litigation fees.

I authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I grant the right to the dentist to release my dental history and other information about my dental treatment to third party payers.

_____
Patient Name

_____ Date: _____
Patient Signature