DR. MARYANA KIROLOS, DDS
7645 Delmar Blvd.
University City, Mo 63130

Office Policy on Financial Arrangement

Insurance Policy

We accept most insurance plans. We will help maximize your dental insurance benefits. Benefits vary from plan to plan, and can change frequently. Insurance coverage estimated by this office is just that; an estimate and not a guarantee of insurance coverage. You should review your coverage prior to your first appointment. You are ultimately responsible for your account. It is your responsibility to present a valid insurance card at your first appointment. We will, as a courtesy to you, file any insurance claims for you; however you are responsible for any co-pays, deductibles, or non-billable amounts not covered by your plan. Payment is due at time of service unless other arrangements have been previously agreed upon.

I have been informed that my Dental insurance is ☐ In-Network or ☐ Out of Network.

Payment Policies

- Fees are determined by services rendered.
- All estimated co-pays and deductibles are due at time of service.
- Your account is due and payable within 14days of billing. A finance charge will be added to any past due accounts.

Payment Options

- We accept Visa, MasterCard, Discover, Amex, Cash & Checks
- Payment of one-half down at the first appointment and the balance at cementation or delivery: crown, bridges, partials, and denture cases

Appointment Cancellation Policy

Your appointment time has been reserved exclusively for you. Please provide 24-hour notification if you need to change your appointment. Failure to do so will result in fees applied to your account.

In the event that this account becomes delinquent and must be sent to collection, the undersigned is responsible for all court cost, attorney's fees, and collection costs. Should it be necessary for the doctor to appear in court regarding this account, his/her expenses for time out of the office shall also be compensated for by the responsible party at a rate of $175.00 per hour.

Consent for Services

I authorize the release of any information relating to dental treatment to third party payers, and/or health practitioners for myself or my dependents by Best Care Dental. I authorize my doctor to submit claims for benefits, for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted for my dependents or myself.

By agreeing in the space below, I fully acknowledge that I have read the above conditions of treatment and agree to their contents.

Signature Date