Milford Dental Group

Anna Chisilenco Raho D.D.S.

Financial and Office Policy

Thank you for choosing our office to provide your dental treatment.

Please review the following and sign the bottom of this form to acknowledge receipt and understanding of our financial and office policies.

*Full payment is due at time of service unless prior arrangements are made before beginning treatment.

*Our office will file most insurance claims for you and we will make every attempt to get remittance from the insurance company. If the insurance balance is not paid within 60 days, you may be billed. Please follow up with your insurance carrier should this occur. The Guarantor is responsible for dependents' balance as well as their own.

*If your account is turned over for collection, you will be responsible for reasonable attorney fees, court costs and agency fees charged by our office.

*Not all insurances have the same coverage. We will attempt to get accurate information from your insurance carrier but if they do not cover your treatment, the charges will be the patient's responsibility.

*For services that are considered major, you may be required to pay at least half of the estimated patient out of pocket at the time of booking or at the appointment before treatment is started.

*Scheduled appointments are a commitment of time between you and our doctors or hygienists. These specific times are dedicated to you by our clinical and administrative staff. When an appointment is missed or canceled on short notice, that time is lost instead of being utilized by another patient. We make every effort to honor all time commitments and ask that our patients do the same. Appointment cancellations without 24 hour notice can result in a charge.

*There is a fee for any checks returned to our office for non-sufficient funds(NSF). The fee will be determined based on what your bank charges our office for returned checks.

I, the patient or guardian of the patient, acknowledge and agree with the above financial and office polices of this dental practice.

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Printed Name

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Signature of Patient or Legal Guardian Date