Dr. Joseph A. Koszelak D. D. S.
605 Division Street
North Tonawanda, NY 14120
Phone: 694-0194

FINANCIAL POLICY

In order to keep the costs of billing down, and in turn keep the costs of procedures reasonable we expect payment at the time of service.

If you have dental insurance, which allows assignment of benefits, we will gladly accept assignment of benefits, and then bill you for the remaining balance, if any. However, we would expect the remaining balance paid within 30 days. If the balance is not completely paid in 90 days from the date of service, interest will be charged on any unpaid balances. We understand that dealing with insurance companies can be frustrating and slow. If this is the case, we will handle interest charges accordingly on an individual basis.

Should your insurance not allow assignment of benefits, we would prefer payment at time of service. Once your balance is paid in full, we will give you a paid receipt along with a filled out insurance form that you can mail to your carrier in order to receive reimbursement for services provided and paid for.

If your balance is not paid in full within 90 days from "date of service", interest will be charged on any unpaid balance. Interest rates charged for overdue balances are, 1.5% per month, 18% annually, plus a $5.00 late charge per month. Should a patient's case be turned over to our collection agency the patient will be responsible not only for interest charged by this office but the collection agency costs as well.

We currently accept cash, personal check, money orders, Master Card, and VISA. Those customers paying by cash or check at the time of service will receive a 5% discount. Using your Master Card and VISA you can preauthorize payment of unpaid insurance balances; the patient needs only to fill out the proper form, which can be obtained at our office.

We understand that certain situations may arise which may make the above payment schedule difficult. If there is a problem please contact the office as soon as possible. The sooner you reach us with the information, the more willing we'll be to work with you.

The decision of the doctor and staff in the above matter is final.

I have read the above statement and understand its content.

Patient Signature:_____ Date:_____