STEPHEN R. JACAPRARO, D.M.D.
FAMILY DENTAL CARE

1379 MAIN STREET
AGAWAM, MASSACHUSETTS 01001
TELEPHONE (413) 786-8177

Financial Policy/Authorization

Payment- Payment in full is expected upon completion of each visit. For your convenience, we accept MasterCard, Amex, Visa, and Discover, as well as personal checks. Please note there is a $25.00 fee for returned checks.

Insurance- As a service to our patients, our office will submit fees for service to certain insurance companies. However, we do consider the patient (or guarantor) primarily responsible for the account. Any co- payments, deductibles or patient responsibilities known prior to the visit will be collected at, or before, the time services are rendered. When claims have been processed by insurance, any remaining balance- if any- is the patient's responsibility. Additionally, the practice is not responsible for knowing what specific procedures or amounts are covered by your insurance policy or the limits of your coverage.

Cancellation- We require one full (24 hours) business days' notice for cancellation of all scheduled appointments. If a notice is not received patient will be financially responsible for a $25.00 inconvenience fee.

Medical Records- There is a fee charge of $30.00 for all copies of Dental records. This request must be made, in writing, at least ten business days prior to the date needed and payment must be made at the time of the request.

I desire to have Family Dental Care provide me with professional services and agree to abide by this authorization/policy. I authorize benefits, if applicable, to be paid directly to Family Dental Care.

I agree to pay any balance due to the practice of Family Dental Care within 30 days of receiving notification (which may be provided via mailed statements, letters and/or telephone) of said balance.

I understand that legal action may be taken if I fail to fulfill the contract, and I will be responsible for all collection costs incurred, as well as any additional attorney's fees that may be assessed by the court.

I hereby authorize photocopies of this form to be valid as the original.

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Patient/Guarantor Signature Date

Printed Name