



Heritage Family Dental
General, Cosmetic & Implant Dentistry
Dr. Larisa Sokolson
Dr. Robert Burstein

OFFICE POLICIES

Today's Date: ___/___/___

Larisa Sokolson, D.M.D.
15 Morgan Farms Drive
South Windsor, CT 06074-1372
860-644-4741

Dr. Larisa Sokolson requires your co-payment in full at the time of service. Cash, Check, Visa, MasterCard, American Express, and Discover are accepted.

As a courtesy, we will submit insurance claims to your carrier, provided we have all the required information. Please keep us up to date on any changes in your insurance coverage. We will request your insurance carrier send any payments directly to our practice. As required by Connecticut Statutes, 45 days is allowed for your insurance carrier to pay your claim. At that time, if your insurance carrier has not paid us, you will receive a bill for the balance. **You are ultimately responsible for your account, regardless of insurance and it is your responsibility to follow up with the insurance company if they have not paid the claim.** We will be happy to assist you in this process. After all insurance is paid, payments are due upon receipt. Balances over 30 days are subject to a 1.5% interest charge per month.

NO INTEREST payment plans from CareCredit are available with approval, which allows you to pay over time with no interest. They have convenient, low monthly payment plans and no annual fees or pre-payment penalties.

Returned checks are subject to a \$40.00 service charge. Should litigation or collection action be necessary there will be an additional charge of 15%, plus all legal fees, court expenses and any and all other reasonable expenses incurred by Larisa Sokolson, D.M.D., will be paid by the party whose signature appears hereon.

Please respect our commitment to excellence in Dental Care by being on time for your appointments. These hours are in demand and missed appointments without 48-hour notice prevents others from receiving needed care. We try to confirm your appointments in advance, however at times we may be unable to reach you. It is your responsibility to keep your appointments. We require at least 48-hour notice to avoid a broken appointment charge. We will make every effort to assist you in providing an appointment time convenient to your schedule; please help us by maintaining your commitment to your dental health.

I have read the above office policies and have received a copy for my records.

SIGNATURE _____ DATE _____