Fern E. Cytryn, D.D.S., FAAPD
Diplomate
American Board of Pediatric Dentistry
Pediatric and Adolescent Dentistry
of Rockland County, P.C.

We are dedicated to providing your child with the best possible care. Your knowledge and understanding of these policies is important for our professional relationship.

As a Pediatric Dentist my relationship is with you and your child. Your dental insurance policy is a contract between you, your employer, and your dental insurance company. This office is not responsible for how your insurance company handles its claims, or what benefits the plan pays on a claim. If we are an out of network provider, we will assist you in providing information the insurance company needs to process the claim. We will provide a claim form to assist you if secondary insurance is involved.

All parents must complete our patient registration forms prior to seeing the Doctor. The parent who brings the child is responsible for the account balance; regardless of the family situation or who carries the insurance.

1. Payment: Payment in full for treatment services is due at the time the services are rendered. We currently accept Cash, Checks, Master Card, Visa, and Discover for payment. We do not hold checks or accept post-dated checks.
2. Insurance: The only insurance plans this office participates with is the Delta Dental Premier Plan, and those classified under the Dentemax network. In the event that there is an outstanding balance from Delta Dental or your specific Dentemax Plan, that account balance is your responsibility and payment is expected at the time of service.
   Whatever your insurance plan, we will still need a copy of your insurance card as it provides the information needed for your claim form's completeness. If you do not have a card, contact your plan.
3. Account Payment: You are responsible for the timely payment of your account. Payment is expected within 30 days of the date on the account statement. There is a 1 ½% finance charge on any unpaid balance for each month your balance is outstanding. In addition there is an added administrative fee of $25.00 to your account for each month your balance remains unpaid. We understand that temporary financial problems may occur which affects timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.
4. Non-Payment: If your account is 30 days past due you will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted. Please be aware that if a balance remains unpaid you will be subject to additional fees that are incurred to collect your balance; including but not limited to administrative, legal, collection agency, etc...
5. Returned Checks: Returned checks are subject to an additional fee. A $50.00 charge for the returned check will be applied to your account balance.
6. Appointments: All patients must be accompanied by their parent for all treatment appointments, and be present during treatment. Once an appointment is made, this time has been specially and specifically reserved for your child. A $75.00 charge will be assessed unless the office is notified 24 hours in advance.
   We understand that unfortunately emergencies can occur. Please let us know as soon as it is feasible so that we can reschedule your child's appointment.
7. Treatment Plan: We will gladly discuss any proposed treatment with you, provide a treatment plan, and answer your questions.
8. Fees: This office's fees are representative of this area.

Thank you for taking the time to review our policies.

I have read and understand these policies and agree to abide by its guidelines.

Patient Name/Names ____

Parent/Guardian Signature ____

Date ____

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