MATTHEW NEARY D.D.S.
JOHN LANZETTA D.M.D.
CHRIS CHONDROGIANNIS

Welcome to our practice. We appreciate that you have chosen us for periodontal therapy and will strive to meet your treatment needs promptly and efficiently.

We offer several options for services we provide:

1. Full payment is expected at time of service.
2. Cash, checks, and major credit cards are accepted
3. Extended payment plans may be arranged with prior approval.

Dental Insurance:
Your insurance coverage may or may not include benefits for periodontal treatment. Benefits are dictated by the terms of your or your employer's contract with the insurance carrier. Plans vary enormously, even within the same company, in levels of reimbursement, excluded services, deductibles, maximum annual or lifetime benefits, and terms of payment. Few insurance plans cover all fees. Many provide partial coverage. Some specifically exclude some or all periodontal services and/or implants. Regardless of coverage, the patient, not the insurance company, is ultimately responsible for fees incurred in this office.

My staff will assist you in submitting the necessary forms for insurance reimbursement. We usually file a pre-estimate, since the insurance company generally requires X-rays, periodontal charting, and a detailed treatment plan. Completed treatment forms are typically submitted after your Estimate of Benefits has been returned to us and treatment has been performed. We will assist you with submissions. Questions regarding the terms of your coverage or delays in payment should be directed to your insurance carrier by you or your employee benefits administrator.

NOTE: For all implant and implant related cases a 50% deposit is required when your appointment is made . Balance is due at time of implant placement unless other financial arrangements have been made……

I understand that I am personally responsible for all fees incurred in this office.
Signature_____ Date_____

I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when appropriate, to other providers rendering medical/dental care.
Signature_____ Date_____