Beth F. Buono, D.D.S., P.C
46 Route 25A, Suite 7
East Setauket, NY 11766
(631) 689-8888

Assignment and Release

I, the undersigned, have insurance with_____
(Name of Insurance Company (ies)
and assign directly to Dr. Beth F. Buono, DDS all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charged whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date Signature

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered to treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. Note: Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. Our office will wait up to 90 days for a payment from your insurance company. If payment is not received within this time period, you will be responsible for paying for your visit in full, and subsequently you will be reimbursed by your insurance company once they decide to release payment.

_____ _____
Date Signature

Broken Appointment Policy

Your appointment is a time especially reserved for you. When you cancel or reschedule your appointment without at least 24 hours advance notice, it creates difficulty for our staff and for the other patients who would have been happy to have had that appointment time. If you cancel or reschedule your appointment without at least 24 hours advance notice a broken appointment fee of $45 will be applied.

_____ _____
Date Signature