NY Kids Dentistry and Orthodontics

110 E. 87th Street, #1A, New York, NY 10128
212-369-2213

130 W. 86th Street, #1A, New York, NY 10024
212-362-3355

Office/Financial Policy:

We value you and your family as patients and appreciate that you have entrusted us with your dental needs. The following is a statement of our financial policy which we require you to read and sign at the bottom of this page:

As you know there is a charge for the pediatric dental and orthodontic services that we provide. Payment is expected at the time services are rendered. For Pediatric dental visits, as a courtesy we are happy to complete all necessary documentation and submit it to your insurance provider, for reimbursement directly back to you. For all Orthodontic services, a form will be provided and you will be responsible for submitting to your insurance company for reimbursement. (Please see the front desk for more information).

Please bring your insurance information and a valid ID to your or your child's visit.

Since you are ultimately responsible for payment for treatment it is our policy to obtain your credit card number and authorization to process claims for payments. By presenting your credit card to the receptionist at the front desk, you authorize without prior notification, payment by credit card for services for the amounts you are obligated to pay (for both pediatric dental and orthodontic services). If you would like to use an alternative method of payment please inform us prior to the appointment.

I hereby authorize JAFFE, D.D.S., DUVALSAINT, D.D.S, & SIEGEL, D.M.D. to keep my credit card on file, which it could be used to charge any visits my child has, as well as to clear any balances on my account.

☐ I choose **NOT TO** leave a credit card on file and I understand that payment in full is due at the time of service. **Late payments will incur a 2% administrative fee.**

Any patients entering or enrolled in a payment plan for orthodontic treatment are required to leave a credit card on file.

There may be a cancelation/no show fee if the patient is not able to make their appointment without giving a 24-hour notice.

Patient's Name: _____ Parent/Guardian's Name _____

Cardholder's Signature:_____Date: _____