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Thank you for choosing Elizabeth Russ Family Dental as your dental health care provider. We are committed to the success of your dental treatment, and want to provide you with the very best service available. In order to reduce administrative costs, and keep our fees low for you and your family, we have added the following office policies.

Patients with Dental Insurance as a courtesy to you, our office will gladly submit to your insurance. We accept most insurance, but please do contact your insurance company to verify your dental coverage. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment NOT covered by insurance.

Patients with Secondary Dental Insurance as a courtesy to you, our office will gladly submit to your secondary insurance. If no response is received from your secondary insurance the account holder is responsible for the remaining balance in the account.

Patients without Dental Insurance: Payment in full is requested at the time services are rendered. We accept cash, check, VISA, and MasterCard. If full payment cannot be made, please inquire about one of the payment plans we offer.

Payment Plans we offer various payment plans and payment options. Please ask our front desk for details.

Past-Due Accounts If payment is not received by the due date printed on the account 30 day statement, your account is considered "past due". Accounts "past due" will be charged interest at a rate of 1.5% per month or a \$5.00 monthly billing fee per statement. If after 90 days the balance is still unpaid, the account will be turned over to IC System Collection Agency. The account holder will be responsible for ALL collection fees that this office incurs while attempting to collect on the unpaid balance through the collection agency. Accounts sent into collections will be marked as "inactive". In order to have your account "Reactivated", and continue to receive dental treatment in our office, the delinquent balance must be paid in full

Acceptance Agreement

I understand and agree with the office policy. I understand the parent or relative bringing a child for dental treatment is responsible for all fees incurred at that visit.

Patient/Responsible Party (please print) _____

Signature _____ Date _____