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Thank you for choosing Hingham Dental Associates, LLC for your dental needs. To provide quality care to our patients and avoid any misunderstandings, we would like to inform you of our office policies.

#### **Dental Insurance Disclaimer**

We do not let dental insurance companies dictate the treatment you need. **Dental benefits are contracts between the policy holder and the insurance company, not our office.** As a courtesy, we file your dental claims to your insurance company for you. We also make every effort to assist you with any questions you may have about your dental insurance plan however, we suggest that you read over your policy, so you know the benefits you have available. **Ultimately, you are responsible for any remaining balance your insurance company does not cover.**

#### **Amalgam Fillings**

We are an amalgam free office. Most insurance companies only pay for 80% of amalgam (silver) fillings. We only use composite (tooth colored) filling material because we believe it is a superior material, better for your overall health, as well as less hazardous for the environment. Often you are responsible for the cost difference between the amalgam filling and tooth colored filling. This also applies for materials used for crowns you may receive. The material for your crown is based on your specific needs not what type your insurance plan covers. The price difference is based on the type of insurance plan you have.

#### **Reasonable and Customary Fees**

We have found that *most* insurance companies cover a *percentage* of their fee. They call their fees the “reasonable and customary fee”. We *do not* base our fees on the insurance companies’ reasonable and customary fee; therefore, they usually do not cover the total cost of your treatment. To help you determine your cost for any treatment you receive we can send a pre-treatment estimate to your insurance company. Any portion not expected to be covered by your plan is your responsibility. This amount will include deductibles and co-payments. **Your co-payment will be expected when treatment is rendered.** How much your insurance company pays depends on which policy you have. Your employer usually chooses your policy. We cannot assist you in choosing a policy other than letting you know if we are an in-network or out-of-network provider. **If your insurance company pays less than expected, you will be billed for the difference. If your insurance company fails to pay within 60 days after we submit your claim, you will be responsible for the full fee.** You must call your insurance company for reimbursement.

#### **Financial Policy**

**Payments and co-payments are expected at the time treatment is rendered for all patients with or without dental insurance.** For your convenience, we accept cash, checks and all major credit cards. We do not accept monthly payment plans in our office

Marital status is not a consideration under any circumstance. The parent accompanying the child or dependent on the day of service will be considered the responsible party. We will gladly provide you with copies of statements for your reimbursement.

In the case that overpayment is made, all refunds will be made by check.

**There is a \$35 service fee for all returned checks. If your account becomes delinquent, you will be responsible for an administrative fee of \$150. This fee does not include court or attorney fees which will also be applied to your balance.**

### Treatment Cancellation Policy

Some procedures require multiple visits. Often a deposit is required at the beginning of treatment to cover the expense of lab fees and initial visits. If you decide to stop or cancel treatment midway through a procedure you are responsible for all charges associated with any completed portions of the dental care you have received. This includes but is not limited to x-rays, exams, diagnostic casts, temporary crowns, bridges, restorations, prophylaxis, or periodontal treatment. Once any outstanding insurance claims have been received and the completed portions of the treatment are paid for any remaining amount of the deposit will be refunded.

### Broken Appointment Policy

When you make an appointment, the time is reserved just for you. **It is considered confirmed.** We will call, text, or email you two days prior to your appointment as a courtesy reminder only. If for any reason, you miss or cancel an appointment without giving 48 hours' notice **more than once** in a 12-month period, your appointment will not be rescheduled, instead only same day appointments will be offered to you. We make multiple efforts to remind you of your appointments. We ask for you to acknowledge the appointment two days in advance. If you do not acknowledge the appointment, we will assume you are not coming and offer the appointment to another patient on our waiting list. We ask you not to leave a cancellation message with the answering service unless it is an emergency. Please call the office during regular business hours to reschedule an appointment. The appointment we have reserved for you is valuable and can be used for patients who are concerned about their oral health and are waiting to be seen. Without adequate notice this valuable time is simply lost.

### Agreement

By signing below, you give Hingham Dental Associates, LLC permission to bill your insurance company directly and state that you understand and accept the terms of our **Financial Policy, Treatment Cancellation Policy, and Broken Appointment Policy.**

*I give permission to Hingham Dental Associates to bill my dental insurance provider for the treatment I have received. I authorize and request my insurance company to pay directly to Hingham Dental Associates insurance benefits otherwise payable to me. I understand my dental insurance carrier may pay less than the actual bill for services and I am financially responsible for all copays, deductibles, denied claims or any other uncovered balance for services rendered on my or my dependent's behalf. **I understand my balance is due at the time treatment is rendered and if my account becomes delinquent, I am responsible for an administrative fee of \$150 plus any court and attorney fees. I understand and accept the above Financial, Broken Appointment, and Treatment Cancellation policies.***

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Patient Name

Patient or Parent/Legal Guardian Signature

Date