J. Alan Sasson, D.M.D.

12 Webster Street
Brookline, MA 02446

617-739-1017

Financial Policy

Thank you for choosing us as your dental health care provider. We are committed to the success of your dental treatment and want to provide you with the best service possible. To help reduce our administrative costs and keep our fees to you as low as possible, we require payments to be made at or prior to the time that you (or your family members) receive treatment. Please indicate below your preferred method(s) of payment.

My preferred payment option is:

_____ Cash

_____ Check

_____ Major Credit Card (Visa, MasterCard, American Express)

_____ ****

A note for patients with dental insurance

Dental insurance normally does not cover the total cost of your treatment. Based on your plan, we usually can **estimate** the amount of your co-payment. Your co-payment is expected when treatment is delivered. If your insurance company fails to pay within 60 days after we submit your claim, you will be responsible for the full fee.

*** For treatment amounts over $300, please inquire about the possibility of an extended payment plan.

Acceptance Agreement

I understand and agree with the above financial policy. I understand the parent or relative bringing a child for dental treatment is responsible for all fees incurred at that visit. I further understand that I am responsible for ALL fees, regardless of insurance coverage.

Patient/Responsible Party _____ (Printed Name)

_____ (Signature)

_____ (Date)