Payment Policies (no insurance)

The number of canals and the degree of difficulty of the treatment determine the exact fee for a root canal. Fees may vary for treatment. Fee may also be added for calcification on any particular tooth.

Anterior: $895	Bicuspid: $995	Molar: $1195
Retreatment-Anterior: $950	Retreatment- Bicuspid: $1100	Retreatment-molar: $1300
Nitrous Oxide: $75	Calcification: $200	

Consultation: $90-$125 (All consultation fees are due at the time of service)

If you do not have insurance, 50% of the total fee will be due at the first visit and the remaining balance due at the second appointment.

Insurance Policies

WE DO FILE ALL INSURANCES (AS A COURTESY), HOWEVER, WE ARE ONLY CONTRACTED PROVIDERS WITH AETNA PPO I, ASSURANT PPO, CIGNA PPO Radius, DELTA DENTAL, DELTA CARE HMO, DENTAL WELLNESS, DENTEMAX, GEHA Connection Dental, HUMANA PPO, METLIFE, GUARDIAN, LINCOLN FINANCIAL PPO, & UNITED HEATLHCARE. WE DO NOT CONTRACT OUR FEES WITH ANY OTHER INSURANCE COMPANY BUT WE WILL FILE YOUR INSURANCE FOR YOU. WE WILL FILE FOR CONSULTATION, TREATMENT, & CALCIFICATION (IF APPLICABLE) PER TOOTH. WE DO NOT ACCEPT ANY DISCOUNT PLANS.
Therefore, you will be responsible for any amount that the insurance does not cover at the time of service. For non-contracted insurances, our fees are at times above reasonable and customary since Dr. Saraf is a specialist. If we are not contracted with your insurance, you will go by the fees stated above. If you have Dual Insurance Coverage, 20% will be due at your first appointment. When payment is received from your insurance company, you will receive a statement for the remaining balance or a prompt refund if a credit exists. As of 60 days, if the office has not received payment from your insurance company, you are responsible for the remaining balance on the account and we will make sure to credit any late payments from the insurance back to the patient.
Please keep in mind that your policy is a contract between you and your insurance company.

For all patients with insurance

Any balance not received within 60 days will be charged to the credit card on file:
Please list credit or debit: _____
Expiration: _____ Verification Code: _____Initials:_____

I/We further agree to pay all costs of collection, including costs of a collection agency if the account is turned over.
A cancellation fee of $75 will be charged for cancellations less than 24 hours prior to the appointment and for no shows as well. Any appointments that are considered a no show, no medications will be prescribed for that patient until they have been seen in our office again.

Please sign and date your signature in the space below, signifying that you have read and agree to the payment policies outlined above.

Signature of Responsible Party_____ Date _____