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**Peter A. Cilento, D.M.D.**  
**Maryam Sholehvar, D.M.D.**

1104 S. Cedar Crest Blvd. Suite 100  
Allentown, PA 18103  
610- 437- 4486

Thank you for choosing Peter A. Cilento, D.M.D., & Maryam Sholehvar, D.M.D. as your dental care provider. Please take a moment to review our Financial Policy.

- **PAYMENT IS DUE AT TIME SERVICES ARE RENDERED**
- **WE ACCEPT CASH, CHECKS, VISA, MASTER CARD AND DISCOVER**
- **WE OFFER 6 MONTH INTEREST FREE FINANCING WITH AMERICAN GENERAL**
- **WE OFFER CARE CREDIT FOR EXTENSIVE TREATMENT PLANS**

Insurance Policies

Your insurance is a contract between you and your insurance company. Professional care is provided to you, our patient, and not to an insurance company. Therefore, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will gladly process your claim, but we request your estimated portion be paid at time of service. If you prefer, we will be happy to bill the exact difference to your Visa, Master Card or Discover account the day the insurance check is received by our office, using a "signature on file" card. In the event we do not accept assignment of benefits, please know that the balance of your bill is still your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 30 days, you will have 30 days to arrange payment of the balance due. Regarding insurance plans in which we are a participating provider, please understand that we do require payment of co-pays and deductibles prior to treatment.

Insurance Authorization and Assignment

I request that payment of authorized insurance benefits be made on my behalf to Peter A. Cilento, D.M.D., or Maryam Sholehvar, D.M.D., L.L.C. to release any dental information necessary to process my claim. I permit a copy of this authorization to be used in place of the original. My insurance company or I may revoke the authorization at any time in writing.

**I have read the Financial Policy. I understand and agree to this Financial Policy**

\_\_\_\_\_  
Patients Name

**X** \_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_ Date \_\_\_\_\_