FINANCIAL POLICY

Thank You for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, American Express, Mastercard, Visa, and Discover. Outside financing is available upon request and approval.

☐ **Please check if you would like more information about financing options.**

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred. If payment becomes 90 days past due, delinquency at the lesser of the annual rate of 30% or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. ***Delta Dental and Blue Cross Blue Shield of MI Policy Holders see Addendum 1***
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, American Express, Mastercard, Visa, or Discover at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE*.

Signature_____ Date:_____

(Patient or Guardian)

ADDENDUM 1

Insurance Acknowledgment

- Blue Cross Blue Shield of Michigan and certain Delta Dental Policies act more as a reimbursement program. We will submit the claim but the reimbursement check will go to the policy holder, and not be paid directly to us, the Dental office. This is because we are considered “Out of Network.”

- We ask that you pay for services in full at time of service, you should see your reimbursement check in 7-15 business days.

- However, we do understand that this can be a financial hardship. Upon approval we will allow you to pay the estimated insurance balance when you receive the reimbursement. We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, American Express, Mastercard, Visa, or Discover at the time we provide the service to you.
    - We require the balance to be paid in full within 10 days of receiving the reimbursement check.
    - Anything unpaid after that will be subject to a 10% service charge.
    - *Keeping an insurance check for services rendered is illegal.*

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Signature_____ Date:_____
(Patient or Guardian)