CONSENT FOR SERVICES AND FINANCIAL POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term of condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

We must have a 24 hour notice to cancel or reschedule your appointment. A $100.00 fee may apply if a timely arrangement has not been made.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

_____

Signature Here **- By signing this form, I understand the above information and agree with its contents.**

Thank you.
Battle Creek Family Dentistry

FINANCIAL OPTIONS

Dear Friend,

We realize that when it comes time to pay for your dental services, many questions can arise. In order to make this part as stress free as possible, we have attempted to explain your financial options in our office.

1. **Payment Plans:** We have made special arrangements with Care Credit to help finance. We have arranged to have interest-free financing for up to 18 months. There is a short application process and we can have an answer for you usually within 1 hour.

2. **Payment the day of service:** Total fee must be paid at the time of your scheduled appointment. No discounts will apply.

3. **Insurance:** We will estimate your co-payment based on the information that we have received by speaking directly to your insurance company. We expect payment of your estimated co-pay and deductible at the time of service. As a courtesy, we will bill your insurance claim. However, we will not become involved with disputes over non-payments, downcoding by insurance companies, UCR, fee schedule issues, or appropriateness of care issues.

   Dental insurance is a contract between you, your employer, and the insurance company. We will not and cannot allow a disinterested third party (your insurance carrier) to become involved with the type of care that we deliver. Please understand that the entire fee for your dental services is your responsibility. If for any reason your insurance carrier has not upheld their financial obligation to you within 60 days of the time of service, you will be expected to make appropriate financial arrangements with our office.

   Dual Insurances: We will estimate your co-pay based on primary insurance. We expect payment of your estimated copay portion at the time of your service. We also expect payment of your primary and secondary deductibles at the time of service. As a courtesy, we will bill your primary and secondary insurance claims.

4. **Payment Responsibilities for Children:** The parent/guardian who brings the child in for care is the person responsible for payment. We do not get involved with financial arrangements concerning split families, Friends of the Court, divorce decrees, or any other arrangements that relieves or attempts to relieve financial responsibility from the parent/guardian who brings the child to the office.

I have read, and, I understand these options.

Patient Signature _____ *Date* _____

Thank you.

Battle Creek Family Dentistry