Dental Health Professionals, P.C.

7800 U.S. 131 South, P.O. Box 889, Cadillac, MI 49601

Phone (231) 775-9797 / Fax (231) 775-9793

FINANCIAL POLICY

Thank you for choosing Dental Health Professionals for your dental needs. We are committed to providing quality dental care for you and your family. Please read the following information, and if you understand our financial policy, please sign in the space provided. We will furnish you a copy at your request.

Payment for dental services is expected at the time of service, this included co-pays and deductibles. Our office welcomes cash, Visa, MasterCard, American Express, Discover, and personal checks.

Our office is happy to submit dental claims on your behalf. Your insurance company may need for you to supply certain information directly to them. It is your responsibility to respond to their request. Your insurance benefit is a contract between you, your insurance company, and your employer. It is your responsibility to review and understand your individual insurance policy.

Anticipation of benefits expected are clearly estimates. Due to constantly changing insurance regulations, benefits and deductibles, we are only able to approximate your insurance balance. If your insurance pays more than expected, you will be credited the difference. If your insurance company pays less than expected, you will be charged the difference. Final responsibility for payment rests with the person responsible for the account.

Please help us serve you better by keeping your regularly scheduled appointment. We will make every effort to confirm your reserved appointments. If we do not receive confirmation your appointment may be released. Appointments that are not canceled prior to the appointment will be considered a no show. No show appointments may result in a broken appointment fee or dismissal from the practice.

Accounts over 30 days past due will have an accrued service fee at the rate of 1.5% per month, or 18% annually. If you desire, we will automatically charge your monthly payment to your credit card each month. If an unforeseen situation should arise that prevents you from making your monthly payment in a timely manner, please contact our office to avoid any misunderstanding.

Our dental practice is committed to excellence. Our goal is to provide the best dental care possible. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party Date