Okemos Pediatric Dentistry, P.C.

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OFFICE POLICY AND FINANCIAL TERMS

Understanding the specific requirements of your insurance plan can be difficult. The following information is designed to help answer any questions you may have regarding your insurance coverage and the payment policies of our office.

If you DO NOT have insurance: We ask that you pay for your office visit at the time of your appointment.

If you have private insurance: Please give your insurance card and any necessary claim forms to the front desk staff during your appointment. You will be required to pay for your visit today. We will make every effort to have that cost available to you by the time you complete your exam.

If you belong to Health Maintenance Organization (HMOS) If we are not affiliated with HMO, you will be responsible for the cost of your appointment. We ask that you pay this fee at the time of your visit.

Fees: We share your concern about the increasing costs of dental care. Because statements and billing fees have become so expensive and in an effort to keep your dental costs down, we ask that you pay your estimated co-payment for your procedure(s) at the time the services are rendered. We will provide you a treatment plan for any treatment diagnosed at the time of the appointment.

Insurance: We remind you that the responsibility rests with the patient being treated or the parent/guardian. For office visits we expect payment at the time of that office visit by cash credit card or checks. We remind you that most insurance contracts involve deductibles and/or percentage allowances with the result that the entire bill is seldom covered in full. Should we receive any payment that exceeds your balance due, the excess will be promptly refunded to you. We know questions can arise on insurance matters and these should be discussed with our front desk staff. We will be happy to help you receive maximum benefits; however the agreement of the insurance company to pay for dental care is a contract between you and the company. Feel free to address any questions regarding your bill to our office at (517) 381-5244.

Cancellations: We require at least 24 hour notice to change or cancel your appointment; otherwise there will be a $50.00 charge to your account.

Payments: Payment is expected when services are rendered.

Delinquency: If your account falls into delinquency, you agree to pay any and all collection agency charges, attorney fees and court fees.

WE OFFER TO BILL YOUR INSURANCE COMPANY AS A COURESTY TO YOU. HOWEVER, YOUR CO-PAY MUST BE PAID AT THE TIME OF YOUR APPOINTMENT. YOU HAVE THE FOLLOWING THREE (3) OPTIONS: (please select one option by placing your initials on ONE of the three selections below).

_____ We will send out a Pre-Treatment Estimate to your insurance company for approval. When we receive the estimate from your insurance company, you will be responsible for amounts they do not cover at the time of your procedure(s).

_____You pay estimated co-pay at the time of our visit and we will bill your insurance company for the procedures performed. You may have a balance after the insurance benefits are received. If you have a balance due, we will bill you for the difference, that payment will be due upon receipt of our bill. If you have a credit due from us, we will send a check for the over payment immediately. Or, if you wish we may apply the credit towards any future services.

_____You pay the entire balance and bill your insurance company yourself

Date _____ Name (printed) _____

Name (signature) _____