MIDLANDS DENTAL
WHERE CARING COUNTS

FINANCIAL POLICY

1. It is requested that payment in full be made at the completion of each visit unless prior arrangements have been made. Our office has financial options available for treatment over three hundred dollars.
2. Insurance is an aid for dental services and the amount your plan pays is determined by which plan your employer chose. Many routine dental services are not covered by insurance plans. As a courtesy, our office will file your insurance claim. We will do all we can to maximize your insurance benefits.
3. Insurance benefits must be assigned to us if payment is not made at the time of service. We request that you pay your estimated portion on the day that services are rendered. Regardless of insurance benefits available, the entire balance is the patient's responsibility and should be cleared upon receipt of the office statement. We believe 30 days is a reasonable length of time to wait for payment from insurance companies.
4. Interest will be charged on a monthly basis on any unpaid balance.
5. Delinquent accounts will be turned over for collection and all costs of collection including attorney's fees (not to exceed 15%) will be charged to the account and are the patient's responsibility.

Patient (Guarantor) _____ Date _____

BROKEN APPOINTMENTS

Changes in reserved appointment time without a day's notice affect other patients who have been waiting to see the doctor(s). It also results in increased dental costs. Time and facilities are reserved for your treatment on an individual basis.

To avoid increasing fees to cover these costs, our office guideline is that those who habitually cancel less than 48 hours before their appointment or do not show up for reserved appointments should incur the increased costs. The patient will be charged $50.00 per appointment hour scheduled for care.

Please help keep dental costs down by letting us know as soon as possible if a change in your scheduled appointment is necessary.

I have read and understand the policies as outlined above and agree to these conditions.

Patient (Guarantor) _____ Date _____

OUR COMMITMENT TO TREATMENT

Our promise is to deliver the best dental care that we are capable of. In return, we ask you care for your dental health on a daily basis to the best of your ability. Incomplete treatment leads to unnecessary problems and complications, such as the loss of teeth. It could also lead to more advanced disease which unnecessarily adds to your cost. Help yourself achieve that goal by following through with your dental plan. We will never begin any treatment without your full understanding of the treatment diagnosed and your financial responsibility.

Patient (Guarantor) _____ Date _____