OFFICE FINANCIAL POLICY

Dear Patient,

Welcome to our office. We are very happy to have you here, and we appreciate the opportunity to care for you and your family. In an effort to maximize our care for you, we would like to take a moment to inform you of our office policies in order to assist you in understanding your financial obligations and responsibilities.

From our office, you can expect us to do everything we can to help you understand treatment necessity, working out scheduling to maximize your insurance benefits, and your time away from your work as much as possible, and help you with financial feasibility so you can best budget for treatment.

From you, we ask you to be aware that **payment is expected at the time service is rendered.** We offer you many options for payment which are as follows:

(1) Cash
(2) Check
(3) Credit card (Mastercard, Visa, Discover, and American Express)
(4) CareCredit-a payment option that allows for 3, 6, and 12 months deferred interest plans allowing for treatment to be completed, and giving patients time to repay their fees interest free. CareCredit also offers low monthly plans to assist you with your budgeting for treatment.

Our goal is to concentrate on your excellent dental care and meeting you and your family's dental needs. We feel that the above financial options allow us to focus on your care as well as help you to meet your financial obligations. We will treatment plan for you doing our very best to **estimate your coverage** by your insurance.

Please note: we are not responsible to know your insurance benefits. That is the responsibility of patient to know their benefits. We are only given a general breakdown of coverage from your insurance company. They do make mistakes in giving information. We expect them to be accurate, but we recognize they often make mistakes. Fine points of your plan are in your benefits book which we do not have access which you are responsible to know. The patient is always responsible for the costs of their treatment and anything not covered by insurance._____(initial)

Please understand there may be clinical indications that may necessitate a change in treatment and your financial obligations. We submit claims to your insurance as a courtesy to you, and we will do our best to encourage your insurance company to pay claims promptly and accurately. Our interest is in serving you well and keeping the focus on excellent care of you.

Please be prepared to pay your co-pay at the start of treatment.

Please note we charge $125.00 for appointments missed or canceled under 24 hours.

We truly appreciate caring for you. We have built our practice by your kind referrals. If you have been referred by one of our patients, please let us know so that we may thank them for their confidence in our office.
Referred by_____

We thank you for allowing us to care for you. We look forward to serving you.

Sincerely,

Anton F. Misleh, DDS

I understand the above statements, and I accept responsibility for my treatment and its costs.

Patient Signature_____Date:_____