HAYDEN RUN DENTISTRY FINANCIAL POLICY

~Payment Policy: Our office is a fee for service office, meaning we politely ask you for your portion of the visit as payment **at the time services are rendered**. For your convenience, we accept:

Cash
Credit Card: Visa
Master Card
Discover
American Express
Personal Check
Care Credit
Dental Benefits

Courtesies:

*Payment in full at time of appointment by check, cash, or credit card receives a 5% courtesy, on treatment exceeding $1000.00.

*Senior Citizen courtesy of 5% with Golden Card at time of service.

~The adult, parent(s), or legal guardian accompanying a minor child is responsible for the family's portion, not covered by any Dental Benefits you may have at the time services are rendered.
~For unaccompanied minors, non-emergency treatment will be denied unless arrangements for payment on a pre-authorized credit card, cash, or check are made prior to the appointment date and time.
~Minors with two separated parents: When two parents are each responsible for one half of the cost of the children's dental care, the parent who brings in the child is responsible for paying the co-payment or full fee. They will also be responsible for collecting payment from the other parent.
~Emergency Patients: There is to be one method of payment ONLY for emergency treatment of a patient new to the practice. Patients must pay at the time of service until they have been established as an existing participating patient and then payment policies will apply.
~We charge a $25 returned check fee and 1.5% interest on all unpaid balances over 31 days up to 90 days at which time accounts are turned over to a collection agency.
~ We charge $1/month billing charge on all unpaid balances over 31 days up to 90 days.
~We try our very best to accurately estimate your portion on the date of service based on the information given to us by your insurance carrier. However, sometimes there is a need to send you a statement, which will be mailed to you the same day payment is received from your insurance company for you visit.
~Our courtesy service to you includes electronic filing your insurance within 24 hours of your appointment so that benefits may be paid directly to our office, researching your plan to advise you of benefits available to you and following the American Dental Association guidelines for coding and filing insurance claims.
~Our expectation of you as the owner of the policy is to make payment in full of fees or co-payments not covered by your insurance plan at the time services are rendered. We also ask that you understand that the policy belongs to you and we have no leverage to obtain payment from your insurance company. With that, we ask that you take responsibility for payment of your visit should your insurance company not pay within 75 days of your appointment date. To avoid this situation, we ask that you keep our office informed of any changes in your insurance coverage or employment.
~Every dental insurance policy has a maximum benefit, which we can track for services rendered in our office. If you have received care by another office, we cannot be responsible for calculating your remaining benefits accurately. You may call your insurance company to receive an updated amount after services have been paid to all offices involved.

CANCELLATION POLICY:
WE ASK FOR AT LEAST 48 HOURS ADVANCED NOTICE FOR CANCELING OR RESCHEDULING AN APPOINTMENT; OTHERWISE A $25 fee per hour scheduled will be placed on account for patients who have a broken appointment, a no-show or short notice (less than 48 hours) cancellation for appointments Monday through Friday 9:00-4:00.

NOTE: All cancellation fees must be paid prior to scheduling another appointment.
The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people---the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment.

I hereby authorize Dr. Kimberly Michalak to release to my insurance company, information acquired during my dental care. I hereby authorize benefits to be paid directly to Dr. Kimberly Michalak. I understand I am responsible for any unpaid balances. I agree to be responsible for dental services not paid by my dental benefit plan. I have read and agree to this financial protocol.

Thank you for understanding our financial policy and please feel free to ask any questions or voice any concerns you may have regarding it.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Hayden Run Dentistry Financial Policy.

Patient Signature

_____