Berrien Dental Financial and Cancellation Protocol

DENTAL BENEFITS – Please provide your insurance card at the time of service. We ask that you inform us of any changes to your dental benefits, address, phone number, or employment status. If you do not have the required insurance information, we may ask that you pay in full at the time of service.

CO-PAYS, DEDUCTIBLES, & NON-COVERED SERVICES – All co-payments, deductibles and non-covered services are due at the time of service. We cannot waive co-pays or deductibles as this would be a breach of contract between you and your insurance carrier.

CLAIM SUBMISSION – We will submit dental claims to all insurance companies as a courtesy. We emphasize that as your dental provider, our relationship is with you, our patient, and not with your insurance company. Your dental benefit plan is a contract between you, your employer, and the insurance company. If a claim remains unprocessed after 60 days, we may ask you to contact your insurance carrier and/or pay the outstanding balance.

NON-PAYMENT – If you have an unpaid balance, you will receive one statement. Should it become necessary to send additional statements for an unpaid balance, you will be charged a monthly service fee of $5.00 and/or be subject to collection proceedings.

RETURNED CHECK – In the event that we receive a returned check due to insufficient funds, or a stop payment; a $35.00 fee will be assessed to your account.

FORMS OF PAYMENT – We accept **CASH, CHECK, MONEY ORDER, MASTERCARD, VISA, DISCOVER, & CARE CREDIT.**

CANCELLATION/NO SHOW POLICY –The office requires a minimum of **24 hours** notice if an appointment must be cancelled. Repeated broken appointments with less than a 24 hour notice will result in you being asked to pre pay any future appointments or being dismissed from the practice.

When patients give our office an advanced notice of their need to cancel a scheduled appointment, this time can then be allocated to patients in urgent need of treatment. In this way, the office can best serve the needs of ALL patients.

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I understand and agree that I will be financially responsible for services provided to me and all costs of collection incurred by the practice should my account be determined delinquent. I have provided the practice with all of my insurance information and will keep this office informed if my insurance coverage changes. I have read and understand the policies and how they affect me and my financial obligations to the practice.

RELEASE OF AUTHORIZATION –I authorize and direct payment by my insurance company to Berrien Dental. I understand and agree that I am responsible for all charges; regardless of any dental benefits.

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Signature of Patient/Responsible Party **Date**

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Printed Name of Patient/Responsible Party