Smiles OF GRAND RIVER

(734) 707-8764
55840 Grand River Ave. Ste 350
Lyon Township, MI 48165

Our Office Financial Policy

Thank you for choosing us for your dental health care provider. We believe that all patients deserve the very best dental care we can provide and that we won't allow your insurance to dictate your dental care. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before being seen by the doctor.

FULL PAYMENT AND/OR CO-PAYMENT AND DEDUCTIBLE/S ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS CREDIT CARDS AND DEBIT CARDS. WE ALSO OFFER FINANCING THROUGH CARE CREDIT AND LENDING CLUB WITH PRIOR CREDIT APPROVAL.

REGARDING INSURANCE

Co-payment, deductibles, and any services not covered by your insurance plan are to be paid at the time the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a part to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental and/or medical policy. **It is the patient's responsibility to know, understand and track their insurance benefits, deductibles and maximums.**

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates**.

ADULT PATIENTS

Adult patients are responsible for full payment at the time of service. If you are unable to pay at this time, be sure to inform us within 24 hours of your scheduled appointment.

MINOR PATIENTS

The adult accompanying a minor and/or the parents (or guardians) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have

been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service has been verified.

PAYMENT PLANS

Smiles of Grand River is a caring and compassionate practice. If you or your family need assistance with payments on necessary treatment, please contact our office to have a consultation with Smiles of Grand River. Your dental treatment is part of your entire medical health and keeping our patients healthy is our first concern.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for a missed appointment at the rate of $50 per hour of reserved doctor and/or hygienist time. We have the right to charge the patient the full cost of their missed appointment. There will be no fee for weather related cancellations, your safety is our priority. Please understand that missed appointment times are valuable to those patients that may find it hard to come to the dentist at other times. Please help us serve you better by keeping your scheduled appointments. Excessive cancellations and no shows will result in termination of our treatment agreement and your records can be forwarded to another dental office for a fee of $10.

BILLING

All accounts which have not paid the estimated portion of their bill at the time of service will incur a $5.00 billing charge each month until the balance is paid. Balances which are 60 days old or older will incur a monthly 2% finance charge which equals an 18% per annual rate. There is also a $50 returned check fee.

COLLECTIONS

Any account that has not received payment in 90 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy. This policy is in effect for all appointments at our office. Please acknowledge that you have had the opportunity to review this policy by signing below.

The undersigned hereby authorizes the release of any information related to all claims for benefits submitted on behalf of myself, spouse, or dependents including the assignment of benefits pay

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Patient Name (Parent/Guardian if minor)

_____ _____

Patient Signature (Parent/Guardian if minor) Date