Alexandra Dodds DDS

2609 Breton Rd SE Grand Rapids, MI 49546
616-245-3205
www.renewdentalGR.com

FINANCIAL POLICY

It is the policy of this office that fees for service are paid at the time the service is rendered. This includes co-pays and deductibles. Certain insurance policies will require payment in full to our office with patient re-imbursement according to the insurance policy. Dependants will require the financially responsible adult to adhere to office policy.

A fee of $62 may be charged for a failed appointment, unless at least a 48 business hour notice is given. A 1.5% finance charge (18% annually) will be added to any balance over 60 days. Balances over 90 days may be subject to collection action by a third party. You agree to reimburse us the fees of any collections agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I have reviewed and received a copy of the appointment policy. I understand 48 business hours are required to cancel an appointment.

CONCERNING INSURANCE

Patients who carry dental insurance should remember that professional services are rendered and charged to the patient and not the insurance company. Because the insurance policy is an agreement between you and the insurance company, all patients are directly responsible for all charges. Patients will be responsible for payment of any difference between fees charged and insurance payments for services rendered. Even though an insurance claim is filed, we cannot be responsible for collecting your insurance claim or for negotiating a settlement on a disputed claim.

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions. I authorize release of information to all my insurance companies. I understand that I am responsible for my bill and that my portion is due at the time of service. I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies. I authorize payment directly to my doctor. I permit a copy of this authorization to be used in place of the original. My signature also applies to my dependents.

I authorize charges to my major credit card for balances due after insurance payment. (optional)

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Name on Card	Card Number	Expiration	3 digit SC

Signature______________________________ Date_________________

Print Name___________________________

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