Miracle Dental
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TO OUR VALUED PATIENT:

Thank you for choosing us as your dental care provider. We are committed to providing you with the best care possible. In order to achieve this goal, we need your assistance and your understanding of our financial policies. If you have any questions or concerns regarding these policies, please feel free to ask any of our staff. If you would like a photocopy of this outline, please ask.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover and American Express. We will submit an insurance claim on your behalf if you show proof of coverage.

Please understand the following:

YOUR INSURANCE IS ULTIMATELY YOUR RESPONSIBILITY

1. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, the patient. If we are a preferred provider, your co-pays/deductibles are due at the time of treatment.

2. Although we routinely try to secure payment from your insurance company by acting as the go-between, all charges are your responsibility whether the insurance company pays or not. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance. Fees for these Services, along with the unpaid deductibles and co-payments are due at the time of treatment.

3. You are responsible for knowing your insurance benefits. Is there a waiting period? Is pre-authorization required for any treatment exceeding $500.00? Is your insurance a PPO or is it an open plan? If we can be of assistance, please let us know.

4. If your insurance company does not pay in full within 30 days, we ask you to contact your insurance company to check the status. If after 45 days they do not pay, we ask, you to pay the balance due. We expect prompt payment from you within 10 days of statements received for any balance due after your insurance has paid.

5. Any balance due on an account over 90 days is subject to an 18% service charge.

6. Returned checks are subject to a $25.00 returned check fee.

7. We reserve the right to charge $25.00 per hour for appointments canceled or broken without 24 hours advance notice.

8. In the event your account is sent to a collection agency, you will be responsible for any collection fees, legal fees or court costs.

9. No minor children (under the age of 18 years old) will be treated without a parent present during treatment.

Our practice is committed to providing the best treatment for our patients. We encourage you to notify us of any changes to your health status or any of the above information.

Signature of Patient / Guardian _____ Date _____