MILES & MICHAEL DENTISTRY

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Financial Policy

Welcome! Thank you for choosing our practice! We look forward to getting to know you and providing your dental care. Please understand that payment is considered part of your treatment, and you are required to read and sign this form before being seen by the doctor. Please let us know if you have any questions.

For ALL Patients: Options include cash, check, card, and Care Credit (subject to approval)

Payments, including deductibles and copayments, are due at the time of the service.

Dental Insurance:
We accept most dental plans and are happy to submit claims **as a courtesy** to you, however, the agreement is between you and the insurance company, and we cannot guarantee that any estimated coverage will be paid once filed. Please note that dental insurance is intended to cover **some, but not all** of your dental care costs. To maximize your benefits, we may refer you to your provider for assistance in understanding your plan.
You are ultimately responsible for all charges for services provided.

Missed Appointments and Late Arrivals:
We require a **24-hour** notice for cancel or reschedule requests. It is important for the well-being of all patients and staff that you arrive on time. If you fail to show or are excessively late, a fee of **$50 or more** will be charged for reserved time, and you may need to reschedule. Numerous missed appointments may force us to discontinue your treatment agreement, and we can forward your records to another office.

Consent:
I hereby consent to the release of payment history and health information for insurance claims for myself and/or named individual(s) for whom I am legally responsible, acknowledging that email or fax is not always secured. I accept responsibility for full and final payment for services provided, and understand that failure to do so may result in my account being turned over to a collection agency. I further acknowledge that payments not made within **90 days** will have a **1.5%** finance charge added to the total.

I had sufficient time to read this document, understand the above statements, and all of my questions have been answered. By signing, I acknowledge and accept these statements and agree to proceed.

_____ _____
Patient Name (Print) **Date of Birth**

_____ _____
Patient or Legal Representative Signature / Relationship (if applicable) **Date**