Maize and Blue Dental
2792 Packard Road
Ypsilanti, MI 48197

FINANCIAL OBLIGATIONS NOTIFICATION

PLEASE READ THE FOLLOWING CAREFULLY AND INITIAL EACH ITEM AND SIGN BELOW:

____ 1. I understand that my payment for dental treatment is expected at the time of service or before.

____ 2. I understand that even after a complete examination and treatment is planned and discussed, my treatment needs may change, resulting in a change in the costs. I understand that I am responsible for the payment of all services received and have the right to ask about the costs prior to the treatment being performed.

____ 3. I understand that all co-pay estimations are not guarantees, but merely estimates of what my insurance company will not cover. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or dependents.

____ 4. I understand that Maize and Blue Dental works with my insurance company on my behalf to maximize my benefits, but I am responsible for all costs, whether covered or not by my insurance.

____ 5. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

____ 6. I understand that for tooth-colored fillings, I may have an additional co-pay of approximately $30-70 beyond what I would normally pay for a similar silver (amalgam) filling. Although I will be notified if a tooth-colored filling is performed, I understand it is my obligation to ask about my additional co-pays prior to completing the treatment.

____ 7. I understand that my payment (including co-pays) for any treatment requiring laboratory work (crowns, bridges, dentures, partials, bitesplints) should be at minimum ½ paid at the first treatment visit. Payment for completion of these procedures should be paid in full by the time of the delivery appointment.

____ 8. I understand that a deposit is needed to reserve the treatment time with the doctor for appointments lasting 60 minutes or more.

____ 9. I understand that if treatment or a service has not been fully paid for, I may not be able to schedule additional appointments in the future.

____ 10. I understand that any unpaid balance on my account of 30 days or more will be assessed a finance charge of 1.5% per month (18% per year). This does not include balances expected from insurance companies.

____ 11. I understand that in the event any unpaid balance is placed for collections with any third party collection agency, a fee of 33% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, and all other expenses so stated elsewhere.

____ 12. I understand that if I do not show up for a scheduled appointment, or if I have cancelled an appointment with less than 48 hours notice, that I will be assessed a fee of $75 and/or may be required to leave a deposit to reserve future appointments.

- I am choosing to leave a credit card # that will be automatically billed for $75 in case I do not show up for a scheduled appointment. _____ _____ _____
  Credit Card # Exp. Date CVV #

- I decline to leave a credit card on file. I understand I will be charged $75 for any missed or broken appointment.

Our practice firmly believes that a good dentist/patient relationship is based upon understanding and good communication. Any questions about financial arrangements or insurance should be directed to the front office managers. I, the undersigned, have read this document and agree to the policies outlined above.

Name _____ Date _____