

FINANCIAL POLICY

Thank you for choosing our practice to provide your dental care. Our number one priority is to provide for you the highest quality care possible. The following is a statement of our Financial Policy, which we ask you to read and sign.

FULL PAYMENT IS EXPECTED AND DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, OR DISCOVER, and CARECREDIT Patient Payment Plans. CareCredit must be used if you need a monthly payment plan. Ask for a CareCredit Brochure for further information.

Regarding Insurance and Fees

You should be aware that some of the services provided to you may not be covered by your dental insurance. We do not limit the quality of our dentistry or our treatment recommendations to the limits of your insurance. Your dental insurance is your financial responsibility – but we can help. We will file all your dental claims and seek the highest benefit to which you are entitled. Regardless of what we might estimate your benefit to be in dollars, we must stress the fact that you, the patient/guardian are responsible for the total cost of the dental treatment. In the case where the insurance does not cover the services provided to you, payment for those services are your responsibility. In some cases, the insurance companies will alternate procedure codes based on their internal policies, which are usually referred to in your benefits materials. You are responsible for this information. All payments are due at time of service. Deductibles and co-pays will be due at time of service and your co-pay is an estimate only. If the insurance check goes to the patient/insured, payment is due immediately.

It is possible at time of service that a charge for your care may inadvertently not be placed on your account when you check out. After billing review, any missed charges will be added.

Your dental insurance policy is a contract between you and your insurance company. We are not a part of that contract, therefore we have no control over the payment policies of your insurance company. They may pay more or they may pay less than we will estimate. A statement will be sent to you informing you of any balance due. Payment is due upon receipt of your statement. Accounts with balances over 30 days old will be charged interest monthly (1.5% monthly, 18% per year). Fees for our services are subject to change without notice.

Minor Patients

The adult (parent or legal guardian of the minor) accompanying a minor is responsible for payment in full. For unaccompanied minors, non-emergency treatment will be denied unless arrangements for payment have been made prior to the minor's appointment.

Missed Appointments

You may receive a courtesy call from my office to remind you of your upcoming dental appointment; it is a courtesy. Do not depend on this call to remind you of your appointment time. Arriving on time for your appointment is YOUR responsibility. If you need to reschedule your appointment time, it must be done so at least 24 hrs in advance of your appointment to avoid a "Failed Appointment Charge".

NSF Checks

The returned check fee will be based on bank charges and may change from time to time.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. Your signature indicates that you have read, understand and agree to the above policy.

Signature _____ Date _____

Witnessed by _____ Date _____

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