MICHAEL DYER DMD
FAMILY AND COSMETIC DENTISTRY

Financial Policy 2024

Payment Options & Discounts:

Payment is due at the time services are rendered.

• Major Credit Cards	Visa, Master Card, American Express & Discover
• Senior Citizens	We offer Senior Citizens (65 and older) a **5%** courtesy discount for treatment done in our office*; excluding implants*.
• Insurance	No discounts available when billing insurance.
• Care Credit Card	Information is available (No or low interest credit card for medical/dental)

Insurance:

Are you currently using dental insurance? YES ☐ NO ☐ (Please check one)

Please present your insurance card at each appointment when you check in. **Ask us to check your benefits if the insurance has changed.** You deserve and expect the highest level of quality, service and care we can provide.

In order to help you maximize your insurance benefits, we will file your claims for you. **However, we cannot guarantee benefits or eligibility of your insurance plan.** We can only **ESTIMATE** what your insurance will cover, and any financial limitations will be your responsibility. We do not process secondary dental insurance. If you have a secondary dental insurance you want to file, please ask for a walkout statement when checking out so you can submit to your secondary insurance on your own.

***Your insurance policy is an agreement between you and your insurance carrier. You are responsible for knowing the policy's limitations. We will strive to estimate your insurance's benefits and limitations; however, you may receive a statement for non-covered charges. Please note that not all dental services are covered benefits in all contracts. ***

Returned Checks:

In the instance of any returned check, a fee of **$50.00** will be assessed. Payment on returned checks must be paid via cash or money order.

Child Custody:

In cases of divorced parents, the parent bringing the child to the dental appointment will be deemed the responsible parent and must pay at time of treatment. Our office will not become involved in custody disputes over which parent is financially responsible for the child(s).

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and conscience sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at my next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date_____ Printed Name_____ Signature_____

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