

DENTAL 1

Dr. Bruce T. Roach, D.D.S.

5270 Highland Road (M-59)
Waterford, Michigan 48327
(248) 673-2400

Financial Policy

This is an agreement between **Dental One**, as creditor, and the Patient/Debtor named on this form.

Payment options:

1. Payment is due the day service is rendered.
2. On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you may pay 50% on the preparation date and the balance upon delivery.
3. We offer special financing through Care Credit. Care Credit offers no interest and extended payment plan options. Please ask us how to apply for and use the Care Credit Plan.

Incidental Charges to Account: We shall have the right to cancel your privilege to make additional charges against your account at any time. Future visits would then need to be paid at the time of service.

Insurance: Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

You agree to pay any portion of the charges not covered by insurance.

Finance Charge: A finance charge will be imposed on the balance of your account which has not been paid within thirty (30) days. The **FINANCE CHARGE** will be computed at the rate of one and one-half percent (1½ %) per month or an **ANNUAL PERCENTAGE RATE** of eighteen (18 %) percent. The finance charge on your account is computed by applying the periodic rate (1½ %-rounded to the next dollar) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is \$2.00 on a balance of \$10.00 or larger. This does **NOT** imply that we agree to directly finance any portion of your treatment.

Credit History: We have the option to report your account status to any credit reporting agency such as a credit bureau if you do not pay your portion in the agreed time period.

Returned checks: There is a \$25 returned check fee. If the check and the returned check fee are not paid in full within ten days, the check may be turned over to the Oakland County Prosecuting Attorney for criminal action.

Missed appointment fee: The third time a patient does not show up for an appointment, or cancels with less than **48** hours notice, a \$25 fee will be charged. This fee must be paid before a new appointment is scheduled.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Oakland County, Michigan.

Waiver of confidentiality: If your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. **After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges.** If the divorce decree requires the other parent to pay all or part of the treatment costs, **it is the authorizing parent's responsibility to collect from the other parent.**

Workers Compensation / Personal Injury: We require written approval/authorization by your employer, worker's compensation carrier or and/or attorney prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Patient's Name PRINTED: _____

Responsible Party PRINTED: _____

Signature: _____ **Date:** _____