FINANCIAL POLICY

Thank you for choosing our office for your child's dental health care needs. We are committed to giving your child comfortable, quality treatment.

Payment is expected at the time of each visit. For your convenience we accept MasterCard, Visa, Discover credit cards. There will be a $25 charge for each check returned from the bank, regardless of the reason.

As a service to you, we will be happy to submit a claim to your insurance carrier for reimbursement if you have supplied us with **complete insurance information** (including the dental claims address). Our office does not participate with Healthy Kids, MI Child, or any other form of State Aid. Please be aware, the amount your insurance carrier allows and/or pays may differ from our fees. Our practice does not participate with or have a contract with your insurance company; therefore, the contract is between you and your insurance carrier. We will ask for your estimated patient portion of the total charges. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid for by your insurance carrier. We can make no guarantee of the insurance company's amount of payment. Claims are submitted promptly after the treatment is rendered. If the insurance company doesn't pay by the 61st day after treatment for any reason, the responsible parent will be billed for the entire amount.

The parent who requests treatment and is present with the minor at the time of their appointment is considered the responsible party for all fees for serviced rendered.

I authorize payment of dental benefits by the insured directly to Grandville Pediatric Dentistry PC. I understand that I am financially responsible for payment of all services or materials provided to my family member and for any yearly deductible or co-payments amounts. I agree to pay all services within 30 days unless a payment plan is negotiated in advance. I understand a monthly billing fee of $4.00 will be added to my account if it reaches the age of 60 days or more. If you are sent to a collection agency, there will be a fee which you will be responsible to pay. I authorize Grandville Pediatric Dentistry PC to release any information required to process my claim. This request shall remain in effect until revoked myself in writing.

It is our office policy to take bitewing x-rays on your child for the first three appointments. Radiographs serve as a valuable adjunct for caries risk assessment. If your child does not have decay or surfaces under observation, your child will be placed on a yearly x-ray schedule.

Signature _____ Date_____

Over →

Dr. Michael B. Demeter
Dr. Sally Kotani • Dr. Agata Lefere
Specialist in Dentistry for children and young adults
3131 - 44th St. SW – Grandville, MI 49418 – 616.531-3430

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practice Form.

_____ Date_____

Parent's/Guardian's Signature

I _____ (print name/ relationship to patient) also give consent for the child/children's treatment to be discussed with the following individuals: (e.g. step parents, grandparents, care givers)

Please print names / relationship to patient:

_____

_____

_____

I also give my permission for information regarding _____ appointments, _____ insurance benefits,

_____financial arrangements to be discussed with the above individuals.