Dental Specialists of Saginaw

Dental Insurance &Payment Consent

If you have dental insurance we will file the claims for you as a complimentary service. We do ask that the correct insurance information be provided at the time of your appointment. We may not be "IN NETWORK" with your insurance company. We do not base our fees on the insurance usual and customary fees unless we are "IN -NETWORK" with them. How much your insurance pays depends on how good your policy is. Our office will provide you with an approximation of your out of pocket expense for any treatment planned. However, please understand that these are only ESTIMATES and are not a GUARANTEE of insurance payment. Any difference in payment from the insurance company is your responsibility.

Payment Options:

1. ***Payment by cash, check, or credit card. If you do not have insurance a courtesy discount of 10% will be offered.***
2. ***Payment financing by Wells Fargo Health Care Advantage or Care Credit - options include 6, 12, or 18 months interest free payment plans, as well as extended payment plans.***

Payment is expected when treatment is rendered. IF YOUR INSURANCE DOESN'T MAKE PAYMENT WITHIN 60 DAYS, YOU WILL BE BILLED FOR THE BALANCE ON YOUR ACCOUNT.

*****Please keep in mind if we are NOT contracted with your insurance company, sometimes the claim payment will be mailed to the patient, WE ASK THAT YOU ENDORSE THE CHECK OVER TO Dental Specialists of Saginaw, or call us to make payment of the estimated amount from the insurance company. If balance is not paid in full after 90 days, the account is at risk of being sent to a collection agency. Any attorney or collection fees incurred due to delinquency in payment will also be charged to the patient. Any personal check returned unpaid or with non-sufficient funds will incur a $20.00 return check fee. Your scheduled time has been reserved for you and the doctor, so we respectfully request a 48 hour cancellation notice.***

I the undersigned have read and understand the above office policies and understand my personal insurance policy. I agree to pay any charges not paid by my insurance company and any fees that apply.

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Signature of Patient or Responsible Party *Date*