Progressive Dental of Ann Arbor, P.L.C.

FINANCIAL POLICIES

Thank You for choosing Progressive Dental as your dental care provider. It is our commitment to provide the best dental care available. The following is a statement of our Financial Policy, please read the entire statement prior to your treatment.

We require payment in full at the time of service unless other arrangements have been made in advance. For your convenience we accept cash, check or charge.

Regarding Insurance:

As a convenience to you, our staff will submit your claim to your insurance carrier. We will do our best to estimate your insurance benefits. We do, however, consider you ultimately responsible for any treatment provided regardless of your insurance plan or coverage. We are not a HMO provider. We welcome you as a patient, as long as you realize that you are responsible for any portion not covered under your plan. Patients should be aware of their policy's limitations, if you are unsure of your benefits, please ask our Insurance Coordinator and they will do their best to help you. In order for us to process your claim we need a copy of your insurance card and claim form. If your insurance company has not paid your account in 45 days, the balance will be automatically transferred to your account for payment.

Minor Patients:

The adult accompanying a minor is responsible for full payment of the child's treatment. Financial arrangements for unaccompanied, non-emergency patient's needs to be prearranged by a parent or legal guardian, with our financial coordinator prior to treatment.

Missed Appointments:

Be advised that the policy of this office is to charge for missed appointments unless they are canceled 48 business hours in advance. Once an appointment has been made, please remember this time has been reserved specifically for you. This enables us to serve your needs better.

Service Charges:

All returned checks will warrant a $25.00 service charge. Accounts carrying an unpaid balance after 30 days will be charged 1% interest per month.

Collection Fees:

Any fees incurred to collect payment will be billed to patient's account.

Financial Consent:

The patient (guardian) agrees to be fully responsible for total payment performed in this office.

Again we thank you for choosing us as your dental care provider. If you have any questions or concerns about our Financial Policy please let us know.

I have read and understand all the Financial Policies.

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Signature **Date**