Sure Smile
1111 Lambert St.
Niles, MI 49120
(269) 262-4689

FINANCIAL & PATIENT RESPONSIBILITY POLICY

The purpose of this form is to inform all patients of our financial policies and your responsibility in regard to charges incurred in our practice. We realize how confusing insurance reimbursement has become and hope this policy will answer any questions you have regarding charges from our practice.

If you are insured by an insurance company with whom we do have a contractual agreement, you will be responsible to make payment for your co-payment and/or any deductible owed at the time of service. We have agreed to accept the discounted rate from your plan, however all co-insurance is your responsibility. We will provide you with the best possible estimate of your obligation and ask that you pay this at the time of service. You will also be responsible for any non-covered services at the time of service.
If you are insured by any insurance company with whom we do not have a contractual agreement, you will be responsible for payment in full at the time of service. It is your responsibility to let us know of any insurance changes. If we do not have your current insurance information, then payment is expected at the time of service. We will file all dental insurance claims for our patients as a courtesy. This does not transfer your financial obligation to your insurance company. We will bill you for any balance left after your insurance company pays us and all applicable write-offs have been taken. If we process your insurance claim, we will wait up to 30 days to receive payment form your insurance company. If we have not received payment, we will then bill you and have you contact your insurance company for payment of their portion to you. If we process your insurance claim and payment is denied or is less than our estimate of your coverage, you will be billed the remainder. If you do not have dental insurance, payment of all services are due at the time of service.

Accounts with balances more than 30 days past due are subject to a monthly finance charge of 5%. If you are unable to pay your account in full, we will be happy to create mutually agreeable payment arrangements with you. As long as the terms of these arrangements are kept, your account will remain in our office for collection. If an agreed payment arrangement is not kept, we reserve the right to forward the account to an outside agency for collection.

Accounts that are 90 or more days past due and remain unpaid will be transferred to a collection agency. You will be responsible for amounts owed to our practice as well as any fees assessed by the collection agency.

Please understand that it is your responsibility to know and understand your insurance coverage and that you are financially responsible for all charges incurred in our office.

I have read and understand the above policy. I give permission for any information regarding my dental care to be released to my insurance company for payment consideration.
Patient/Guardian
Signature:_____Date:_____