

Financial Policy:

We understand and appreciate your concerns regarding fees associated with your treatment, and feel that you should have a clear understanding of your financial commitment for services provided. We will be happy to discuss fees anytime prior to treatment. And you as our patient should fully understand our mutual obligations and responsibilities.

Patients with Insurance:

AS A SERVICE TO YOU, WE WILL COMPLETE AND FILE YOUR INSURANCE CLAIM FORMS FOR COMPLETED TREATMENT. YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY; WE ARE NOT A PARTY TO THAT CONTRACT. WE MUST EMPHASIZE THAT AS DENTAL CARE PROVIDERS, OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY, THEREFORE, ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.

PLEASE REMEMBER THAT INSURANCE PLANS ARE USUALLY NOT DESIGNED TO PAY FOR EVERYTHING. WE URGE YOU TO READ YOUR POLICY. WE WILL DO OUR UTMOST TO SEE THAT YOU RECEIVE MAXIMUM BENEFITS WITHIN THE STRUCTURE OF YOUR INSURANCE PLAN.

YOUR PORTION OF PAYMENT (THE COSTS YOUR INSURANCE WILL NOT COVER) IS DUE AT THE TIME OF SERVICE.

Patients with no insurance:

If you have no insurance, payment for service is due at the time of treatment. To assist you we offer the following options for payment: CASH/CHECK or MASTERCARD, VISA OR DISCOVER.

Contract to Pay for Dental Services

In consideration of the required professional services provided to the above patient, I/we agree to pay the account for these services in full, at the time of service, unless other arrangements have been made with The Mill Creek Dentist. I/we authorize The Mill Creek Dentist to receive assignment of insurance payments. Any charges in excess of the benefits allowed under the responsible party's insurance plan, I/we understand that I/we are responsible to pay the difference. A finance charge of 1.5% monthly (18% APR) will be added to my outstanding account balance after 30 days.

Authorization to Release Information

The Mill Creek Dentist is hereby authorized to release any dental or incidental information that may be necessary for dental care or processing insurance.

Legal Responsible Party

If the patient is a minor and/or under custodial care, the below responsible party represents that they are legally authorized to obtain dental care or provide information for processing insurance.

By signing your name you are agreeing to this patient registration contract and acknowledging our financial policy. I also attest that all patient, spouse, health and dental information provided is accurate.

Signature: _____ Date: _____