

Financial Policy & Patient Responsibility

Thank you for choosing Dentistry at Westland for your dental needs. Our goal is to provide you with the highest quality and most comprehensive dental care possible. Payment of dental services is the responsibility of the patient in the patient-dentist relationship. Therefore, we would like to explain our payment policy and patient responsibility expectations to you to ensure understanding and compliance.

Payment & Payment Options

- **Payment for dental services is due at the time of service
- **We accept Cash, Check, Visa, MasterCard, Discover or American Express
- **A bank charge of \$25.00 for returned checks due to non-sufficient funds

We believe it is your responsibility to complete treatment and follow a recommended dental maintenance schedule. If treatment plans are not followed and appointments are missed, adverse results could affect your dental health. If you do not proceed with your treatment plan in a timely manner, further treatments for the involved teeth etc. can be affected.

_____ (Initials) I understand the above information

Appointment Commitment

If it is necessary for you to change/cancel your scheduled appointment, we request that you give us 48 hours notice. There will be a fee of \$50.00 per missed appointment.

_____ (Initials) I understand the above information

Insurance Policy

Dr. Richard Calabrese provides many types of dental services within his practice. Many insurance carriers have their own specific criteria set for how frequently an exam or procedure etc. can be performed in addition to not paying for certain types of services due to frequency, waiting periods or insurance plan guidelines. Consequently, it is impossible for us to know all of the many different employer group benefits from one employer to the next. Therefore, Dr. Richard Calabrese or his staff will not be held responsible for informing the patient whether a particular service is covered or not. Our staff will submit all necessary claims to your insurance carrier and provide any necessary information to assist in the payment of your claims. **We ask that you carefully review your policy and/or contact your insurance carrier so you are aware of benefits, frequencies, limitations, and/or restrictions. You are responsible for any charges not covered by your insurance carrier. Insurance co-payments, coinsurance, deductibles, and non-covered services are to be paid at the time of service.**

Please be aware that your dental insurance has a yearly maximum and any charges over that amount will be your responsibility. We are providing the highest quality of dental care for you and your family regardless of insurance frequencies, limitations and/or restrictions. It is your responsibility to provide us with any changes regarding your insurance carrier.

_____ (Initials) I understand the above information

Financial Responsibility

I further agree to pay all finance charges, collection cost, attorneys fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

By signing below, I acknowledge and understand the Financial Policy of Dentistry at Westland, LLC and accept all payment terms under this Policy as well as my financial responsibilities as a patient at Dentistry at Westland.

Signature of Patient or Person Responsible for Account

Date