DRUSKOVICH DENTAL, P.C.
45140 M-51 West
Decatur, Mi 49045
(269) 423-7866
contact@druskovichdental.com
www.druskovichdental.com

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

Payment/copayment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard or Visa.

Returned checks and balances older than 30 days may be subject to additional collection. Charges may also apply for broken appointments and appointments cancelled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer questions relating to your insurance. However, you must realize that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

Not all services are a covered insurance benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover. Any services not covered will require payment in full at the time services are rendered or upon notice of insurance claim denial.

We must emphasize that, as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask us.

I, (Print Name)______________________ have read and understand the Financial Policy of Druskovich Dental, P.C.

Signature: ____ Date: ____________________

ASSIGNMENT OF INSURANCE BENEFITS *Patients with insurance read and sign below.*
I hereby assign all dental insurance benefits to Druskovich Dental, PC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not pay by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: ____ Date: ____________________