

McNiel Family Dentistry, PC.

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1905 Abbot Rd. • East Lansing, MI 48823

(517)351-6140

Financial Policy**Patient****Name:**

Last

First

MI

Preferred Name

We appreciate the opportunity to serve you! We've found that a clear understanding of our financial policy in advance of dental care helps to relieve some of the anxiety associated with dental visits. Patients without insurance coverage need to know . . . The fee for the treatment rendered must be paid in full on the day of service. Patients with insurance coverage need to know . . . The estimated patient copay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that you are ultimately responsible for all fees generated by your treatment regardless of insurance coverage. Any unpaid balance over 90 Days may accrue interest charges of 4.5% per month. McNiel Family Dentistry, PC reserves your appointment time exclusively for you; we don't "double-book" and keep extra patients waiting in case you can't come. Please be considerate. Two business days notice is required for rescheduling appointments. A \$120.00 fee will be charge to compensate for the amount of time that was reserved for you. This fee is not covered by insurance and must be paid prior to additional appointments being scheduled. This fee will be applied to your account for rescheduling, canceling or failing to show up for your appointment without 2 business days notice.

We accept Cash, Checks, Debit Cards, HSA Cards and Benefits Cards with no surcharge applied. I have been informed that payment by Discover, MasterCard, Visa, American Express or Care Credit will have a 3.5% surcharge applied to the amount due for dental services and goods. *

☐ Yes ☐ No

I agree that McNiel Family Dentistry, PC can store encrypted credit card information to facilitate ease of payment. *

☐ Yes ☐ No

Please send statement via: *

☐ Email Statement ☐ Paper Statement

**Guarantor
Email**

By signing this agreement, you consent to treatment by McNiel Family Dentistry, PC and staff and agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Signature _____ Date _____

Relationship to Patient: _____

Response Date: _____