Michael A. Lovda, D.D.S and Associates

INSURANCE AND FINANCIAL POLICY

At Michael A. Lovda, D.D.S and Associates, we believe that you deserve the best dental care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to thousands of patients. Some have dental benefits but some do not. If you have dental benefits, here are some important things you should know:

INITIAL

______Your dental benefits are based upon a contract made between your employer and an insurance company. **Dental benefit plans will never pay 100% of your dental care. It is meant only to assist you.**

______We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list.) We are also a participating provider for multiple PPO insurance companies. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage.

______We will bill your insurance as a courtesy. If insurance does not pay us within 90 days, Michael A. Lovda, D.D.S and Associates reserve the right to request payment in full from you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

______ Michael A. Lovda, D.D.S and Associates does require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, American Express, cash, and checks. If you are in need of an extended finance option, we also work with CareCredit, who offers 3, 6, or 12 month "same as cash" of longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

______ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 48-hour** notice. If you do fail or cancel an appointment, there will be a $125/hour fee.

I agree with the above conditions.

Print Name:____Date:____________

Patient/Parent Signature:____________________________________Date:____________