Jay D. Deiglmeier, DDS, PS

FINANCIAL POLICY AND AGREEMENT

The goal of Panther Lake Dental and Dr. Deiglmeier is to make sure you receive the highest quality dental care and services. One step is to make certain that our financial policy is clear and understood by you.

INSURANCE

We will bill your insurance carrier as a courtesy to you. Please note that not all services are covered benefits in all insurance contracts. Some insurance company's arbitrarily select certain services they will not cover. We recommend you become familiar with your insurance coverage and limitations.

PAYMENT OPTIONS

- Payment in Full
  - A 5% professional courtesy is given if patient portions are paid at the time of service
  - We accept cash, check, Visa, MasterCard and Discover

- Partial Payments
  - 3 months with no interest with a credit/debit card number on file to be ran monthly
  - 6 months with a credit/debit card number on file to be ran monthly

- Interest Free Financing through CareCredit
  - Please inquire for more information

PATIENT RESPONSIBILITY

I acknowledge my responsibility for payment of the services received from Panther Lake Dental and Dr Deiglmeier in accordance with their regular fee's and terms. I understand my responsibility is not modified by whether my third party (insurance) pays for all, part or none of the charges. I understand that this becomes delinquent if not paid within 90 days after billing and that at that time a Finance Charge of 1.0% of the unpaid balance will be charged every month until the balance is paid in full. Additionally, I understand my account may be turned over to a third party for collection should I fail to pay for services provided.

CANCELLATION POLICY

We respectfully request 48 hours notice for any scheduling changes. If we do not receive the requested notice, you may be charged for missed appointments. _____
(patient initials)

ASSIGNMENT AND RELEASE

I authorize payment to be made directly to Dr. Deiglmeier by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any dental care information requested by my insurance carrier.

Again, thank you for choosing us as your dental care provider. We appreciate your confidence in us and look forward to helping you with your dental needs and desires.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)