Michigan Endodontics, P.C. Blue Water Endodontics

Steven E. Fegan DDS, MS, Derik P. DeConinck DDS and Associates

Patient Financial Responsibility

1. Payment in full is expected on the day in which services are rendered. We accept cash, checks,Visa/MasterCard and Care Credit. ***There is a $50 charge on all returned checks.***

2. All co-payments, deductibles and non covered services must be paid in full at time of service.

3. As a courtesy to our patients, we verify benefits based on the information given to us. Our office is unable to provide exact co-payments until receipt of payment is received from your insurance company. If the insurance company pays a lesser amount, or denies the claim, the patient will be responsible for the difference. If the insurance company pays more than the estimate, the patient will be sent a refund. Estimates may not include dental work that was recently completed or submitted by another dental provider.

4. Our office submits claims to your insurance company as a courtesy service to you. Services rendered that are not covered by your insurance plan are the patient's responsibility. It is important to know what services your insurance plan covers; we take no responsibility to know what services your insurance plan covers. Any unpaid balance that remains after the insurance payment is received is the responsibility of the patient.

5. ***A monthly service charge of 1.5% will be assessed to all outstanding balances after 30 days.***

6. Accounts over 60 days past due may be referred to a collection agency and such accounts may be reported to a national credit agency. If your account is sent to a 3rd party for collection, you will be responsible for a $50 fee added to your balance and any additional collection and/or court costs.

7. If you request a copy, or transfer, of your dental records there will be a $50 processing fee.

8. No Show/Canceled Appointments. If an appointment is made and the patient does not call to cancel the appointment 24 hours prior to their appointed time, there will be a $50 cancellation fee. Our office does not accept cancellations or changes in appointments by voicemail or email.

Patient Name (Last, First, Middle Initial): ____

Patient Signature: ____
Please note: if patient is under 18yrs old, parent/legal guardian signature required above

Today's Date: ____