VANSLAMBROUCK
FAMILY DENTISTRY

FINANCIAL POLICY

VanSlambrouck Family Dentistry
455 Butternut Drive
Holland, MI 49424

Ph : (616) 394-4700
Email: svanslamdds@gmail.com

Patient Name: _____

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy which we require you read, agree to and sign prior to any treatment.

General:
Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered.

Payment:
Payment is due on the day professional service is provided. If you have insurance, we make every effort to estimate your expected patient responsibility to be collected. This is only an estimate and there may be additional out of pocket expenses after insurance has processed.

Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit.

Returned Check Fee:
In the event a check is returned for insufficient funds, a fee of $40 will automatically be assessed to your account.

Past Due Accounts:
Unpaid balances over 60 days will be subject to monthly interest of 1.5% (compound annual rate of 18%). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovered of the monies due on the account.

Missed Appointments and Cancellations:
Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 24 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or called appointments. Multiple failed appointments may result in

being dismissed from the dental practice.

Minors Accompained by the Parent or Legal Guardian:
The parent or legal guardian accompanying a minor who has consented to treatment are responsible for payment at the time of service.
Unaccompanied Minors: *The parent or legal guardian is responsible for payment at the time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.*

Communications with you:
By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. By providing a mobile number, you agree that VanSlambrouck Family Dentistry may send you automated appointment and dental marketing messages to the mobile number provided. I understand my consent is not required for purchase. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may make such call to a mobile telephone or other similar device.

Consent:
I, _____ (patient/guardian name) have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to VanSlambrouck Family Dentistry. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

_____
Patient/Guardian Signature

_____
Date