BAYWEST FAMILY DENTAL
30090 23 MILE ROAD
CHESTERFIELD, MICHIGAN 48047
(586) 949-2240

Office Policies:

Operatories:

____ It is the policy of the office that **only the patient** is allowed in the operatory: in the event that the parent/guardian is needed to accompany a child, it is up to the discretion of the provider if they will be allowed to stay in the operatory for the length of the appointment. However if a parent/guardian wishes they will be permitted to walk a minor to the operatory but then must return to the waiting room.

Payments:

____ **PAYMENT IS EXPECTED AS SERVICES ARE RENDERED**. We accept cash, checks, Visa, MasterCard, Discover, American Express and Care Credit. Any checks returned by your bank will be subject to a charge of twenty-five ($25.00) dollars; this is subject to change without notice. **There will be a charge for appointments missed or canceled without a twenty-four (24) hour notice (forty-eight (48) hour notice for Saturday appointments).**

Insurance

____ With the ever changing policies that Insurance companies are now introducing we do our best to estimate accurately what your co pays would be as well as payment from your insurance company. The agreement is between you and your insurance carrier, insurance carriers do not guarantee payment to our office, and any fees quoted to be paid are only an estimate. Unfortunately however in some cases we run into problems receiving payment. Bay West Family Dental will attempt to comply with the insurance companies requests in any way possible. **If your insurance company denies your claim after our attempts you the patient are responsible to pay Bay West Family Dental in full, and any reimbursement that may come from your insurance company would go directly to you.**

____ **CO PAYS**- Accurate and complete information is required at your first visit**. If you have a co pay, you are required to make the payment at the time of service.** WE DO NOT BILL FOR COPAYS. If your policy requires a deductible or co-insurance, we will estimate your patient portion. If you have a balance due, you will be billed accordingly. In the event of an overpayment, you will be refunded once all claims have been paid. We know co pays and co-insurance have continued to rise. Please understand we cannot reduce or waive your co pay or co-insurance. If you have a financial hardship or difficulty with your payments, please speak with a patient coordinator to discuss your options prior to treatment.

____ **INSURANCE CHANGES** - If your insurance changes during the course of treatment, you must provide this information prior to being seen at your next appointment. Many insurance companies

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require authorization that will not be backdated for any reason. If there is a time lapse between the effective date of your new policy and informing the office of your new insurance you will be responsible for any claims that are denied for any reason including lack of referral and/or authorization.

____ **NO INSURANCE -**If you are not insured, payment will be expected in full at the time of service. Please speak with a patient coordinator if you have any questions prior to the start of your treatment.

____ **MEDICAID**- Our office accepts Medicaid until your 21st birthday. Once you have reached the age limit for our office you may ask for a referral to another office for further treatment.

____ **MINOR PATIENTS**- The adult consenting to treatment for the minor patient will be held financially responsible for services rendered.

____ **TRANSFERRING OF RECORDS-** If, for any reason, you would like a copy of your entire record, you must request in writing, and pay a copying fee of $1.00 per page. For your protection, please have proper ID with you if picking your records up in the office.

I have read the above and fully understand what I have read. I agree to honor my financial commitment to this office as outlined.

Signature of Patient/Guardian_____ Date_____