MISKOVICH
DENTAL CLINIC P.C.

Credit Policy and Patient Responsibility

Thank you for choosing Miskovich Dental Clinic, P.C. as your dental health care provider. We are committed to your treatment being successful. Please understand that prompt payment of your bill is considered part of your treatment. We have put together the details of our Credit and Financial Policies below. Please read carefully and sign below to begin treatment:

- All patients complete our information and insurance forms.
- Full payment or estimated patient portion is due at the time of service.
- For your convenience, we accept cash, checks, Visa, MasterCard, American Express, Discover or Care Credit.
- We offer a 3 month payment plan with prior credit approval and signed agreement.
- A finance charge of 18% annually (1.5% per month) will begin accruing after 90 days from the date of service.

PATIENTS WITH INSURANCE COVERAGE

We may accept assignment of insurance benefits after your second visit. However, we do require your estimated patient portion be paid at the time of service. The balance incurred is your personal responsibility whether your insurance company pays or not. Coverage amounts vary from policy to policy and we cannot guarantee the amounts of coverage offered by your insurance carrier. It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. You understand that your insurance policy is a contract between you and your insurance company. This office holds no party to that contract and will not be held responsible in the event your insurance company denies any claim.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients. Our fee is what is usual and customary for our area. You are responsible for treatment fees regardless of what your insurance company's arbitrary discrimination of usual and customary rates.

DELINQUENCY

In the event your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred by this office.

I have read and understand Miskovich Dental Clinic, P.C.'s Credit and Financial Policy with respect to payment on my account.

Printed Name: _____

Signature: _____ Date: _____