OFFICE POLICIES AND GUIDELINES

Please read over our policy's and guidelines carefully.
Copies can be given upon request.

I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance.

I understand that I may be charged a 1.5% per month, or 18% per year finance charge if my balance goes beyond 30 days.

I give permission for my dentist and his/her clinical team to take any necessary x-rays, photos or study models to enable complete diagnosis and treatment.

I give permission for my dental benefit payments to be paid directly to Dr. Becicka from my insurance company.

I am aware that co-pays and estimated patient portions are due day of service.

I am aware that there will be a $20 service charge applied to any account we receive a returned check for.

I am aware that there is a 2% MN CARE Tax charge added to my services.

I am aware that there will be a fee charged to me on my THIRD Failed / Short notice / Cancelled appointment of $55.00.

We do offer a 10% Discount to patients with NO insurance who pay with cash or check in full day of service. (Check cards are not included.)

In a case where we are forced to turn an account over to our collection agency a 30% business fee will automatically be charged to your outstanding balance.

Signature: _____ Date: _____