

LAPEER DENTAL CENTRE MGT., INC.
381 N. Saginaw * Lapeer, MI 48446 * (810)664-4542

Financial Agreement

Patient Information:

Date: _____

Name- Last: _____ First: _____ Dr. Mr. Mrs. Ms.
Home Address: _____ City: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Birth date: _____ SSNumber: _____

Person Responsible for payment of the account _____
Place of Employment: _____ Position: _____
Address: _____ City: _____ Zip: _____
Birth date: _____ Home.Phone _____ Work Phone _____
Dental Insurance Company _____ Policy Number _____

Spouse's Name: _____
Birth date: _____ SSNumber: _____
Spouse's Place of Employment: _____ Work Phone: _____
Address of Spouse's Employer: _____
Dental Insurance Company _____ Policy Number _____

Financial Policy

We require that you pay your estimated share now. We will bill your insurance carrier(s) as a courtesy to you, although you are responsible for the entire balance. We will set aside for 30 days that portion of the balance which we estimate your insurance carrier will pay. If your insurance carrier does not send payment within 30 days, the balance will be due in full from you. We are not a party to the agreement with your insurance carrier. It is therefore your responsibility to contact your carrier and establish why they haven't paid or paid less than originally stated. If your carrier later pays us more than the estimated balance, we will promptly refund the difference to you.

If you do not have dental insurance, or if we do not accept it, we require payment in full at the time of service.

Note: I certify that the above information is accurate, and that having read a copy of the office policy regarding insurance coverage, I understand that regardless of any insurance, I am responsible for my account.

SIGNATURE OF PERSON RESPONSIBLE FOR PAYMENT OF THE ACCOUNT:

_____ Date: _____

Today's payment will be paid for with: CASH CHECK CREDIT CARD