KATHLEEN M. STRATTON, D.D.S., P.C.
890 SOUTH WASHINGTON AVENUE, SUITE 120
HOLLAND, MICHIGAN 49423

TELEPHONE (616) 355-7009

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

1. Because the expense of preparing and mailing statements has a direct effect on the cost of dental care, **we request payment at the time services are rendered.**

2. As a courtesy to you, this office will assist you in the submission of claims to all insurance companies whenever possible. Please provide your insurance card if you have one.

3. We emphasize to you that our relationship is with you, NOT your insurance company. All charges are YOUR responsibility from the date services are rendered.

4. Balances older than 60 days are subject to a 1.5% monthly service charge (minimum $1.00)

5. **This office no longer participates with the Medicaid program**. We do accept MI Child and Healthy Kids programs that are administered by Delta Dental

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the myself or the person named below and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless payment arrangements are agreed upon in writing. Charges shown on statements are agreed to be correct unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for dental services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or pending of claims. All proceeds of insurance are assigned to this office where applicable, but this office does not assume responsibility for collection thereof. (A copy of this agreement is as valid as the original.)

FINANCE CHARGES are calculated each month on unpaid balance amounts. Accounts 60 days past due will be subject to a 1.5% per month service charge or $1.00 on the unpaid balance, whichever is greater.

NOTICE: By signing this agreement, you agree to the conditions above. You are entitled to a copy of this agreement at the time you sign.

Patient Name_____ DOB_____

Signature _____ Date_____

Responsible Person