

Terms and Conditions

FINANCIAL POLICY

Payment is due at the time services are rendered unless prior arrangements have been made.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless prior arrangements are made.

UNPAID BALANCE:

1.5% per month (18% APR) interest will be charged on overdue accounts past 60 days. In case of default, I agree to pay reasonable costs for collection including attorney fees, court costs, etc.. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third-party debt collection agency.

MISSED APPOINTMENTS:

Appointments that are missed or canceled with fewer than 24 hours business hours' notice require a deposit before they can be rescheduled. After a broken appointment, the next hygiene visit will require a \$50 refundable deposit, and appointments with the doctors will require a \$100 refundable deposit. If the rescheduled appointment is kept, the deposit will be fully and promptly refunded. If that appointment is also missed, the deposit will be forfeited.

Health Questionnaire Acknowledgement and Consent To Proceed: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical conditions or medication can affect dental treatment, I understand the importance of and agree to notify the dentist of any subsequent appointment.

I authorize Dr. Mirci and/or such associates to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement an/or administration of any sedative (including nitrous oxide) analgesic, therapeutic and/or pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include but are not limited to bruising, hematoma, cardiac stimulation temporary or rarely, permanent numbness and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly be quite painful both during and after procedure and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may be or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Authorization must be signed by the patient, or guardian, or nearest relative in the case of a minor, or when the patient is physically or mentally incompetent. I have read the above "Terms & Conditions" and "Health Questionnaire Acknowledgement and Consent to Proceed" and hereby fully agree to their content. I hereby authorize Mirci Dental to use the following signature for proof of signature on insurance claim forms.