

WELCOME TO OUR OFFICE!

FRANK HOLECEK, D.D.S.

3374 E. Jefferson
Detroit, MI 48207

GERALD STEFAN, D.D.S.

2510 S. Rochester Road
Rochester Hills, MI 48307

Please let us welcome you to our family dental practice. We look forward to serving you for all your dental needs. Our mission is to provide the finest comprehensive dental care available in a caring, patient-friendly environment. Please feel free to inquire about any service you may need or want. We hope to make your visits with us as pleasant as possible.

FINANCIAL POLICY

1. Payment is due at the time service is rendered. Payment may be made by cash, check, Mastercard, or Visa.
2. If you have dental insurance, we will be glad to take assignment. This means we will ask you to pay only what your insurance does not cover. Due to the many changes in dental insurance policies, it is no longer an easy task to interpret each individual policy. We will try to estimate for you as accurately as possible what your dental insurance may pay for your dental treatment. However, please realize that we cannot guarantee exactly what your dental insurance may pay for any given procedure. It is your responsibility to know your individual coverage. **Remember that your insurance policy is between you and your insurance company and not with the insurance company and your dentist.** If your insurance company has not paid within sixty (60) days, we ask that you pay the insurance portion.

In order for us to provide this service, we ask that you do the following:

- Assign insurance benefits to our office.
 - Provide identification and group numbers for each policy.
 - Upon request, provide a benefit booklet or a toll free number we may call to verify or estimate what your coverage will be. If we cannot confirm your coverage, then you will be expected to pay the entire fee at the time of service.
3. We will provide your insurance company with all available information to enable you to get the most coverage from your policy.
 4. For dental services requiring multiple visits (e.g., crowns, bridges, root canals), 50% of your payment or co-payment is due at the first visit and 50% is due at the completion of the procedure.
 5. When a service is rendered to a child of divorced parents, we expect payment from the parent accompanying the child.
 6. An interest rate of 1.5% will accrue monthly on any unpaid balance over 60 days.
 7. **Please notify us at least 24 hours in advance of any appointment you cannot keep so we may reserve the time for someone else.** A \$50 charge will be applied to your account for each half- hour of missed appointment time with the dentist, \$25 charge for a missed appointment with a dental hygienist.
 8. A fee of \$30 will be charged for any returned check.
 9. If special financial arrangements need to be made, please speak with the office manager **before** treatment begins.

I have read and agree to follow the above financial guidelines.

Signed _____ Date _____