GENERAL DENTISTRY

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PATIENT RESPONSIBLITY

Our mission is to deliver the finest, most cost effective health care treatment available today. **Please keep in mind that professional care is provided to you and not to an insurance company. Thus, the insurance company is responsible to the patient and the patient to the doctor. We will help in every way we can in filing your claim and handling insurance questions from our office on your behalf. All claims are submitted when your treatment is completed. If your insurance carrier accepts assignment of benefits; we ask that you assign your insurance benefits to us** and we will ask for your estimated co-pay at the time of services.

Dental insurance is a wonderful tool that helps you cover some of your dental costs, but unlike medical insurance, dental insurance will not cover all of your dental care.
PLEASE NOTE: Almost all dental insurance companies have an alternate benefit provision that allows the insurance carrier or third- party payer to determine the benefit based on an alternative procedure that is generally less expensive than the one provided or proposed by the servicing provider. Please ask us if your need any further clarification.

You will have estimated co-pay at the time of your appointment. The estimates provided will be based upon information supplied to us by your dental insurance carrier(s). Some dental carriers may not provide us with the information needed to give you an accurate estimate. The patient is legally obligated to pay the portion of the contracted fee, not covered by the insurance company, in the instance that Dr. Bydalek's office is a participating provider with patient's said insurance company. OR the patient responsible for the portion of the office fee not covered by the insurance company; in the instance that Dr. Bydalek's office is not a participating provider with patient's said insurance company. For patients not receiving benefits from an insurance company, we will ask for full payment of the charges accrued at the time of services. We have multiple payment options available Cash, Check, Visa or MasterCard. (We may ask to see your driver's license).

A finance charge of 18%APR will be assessed to ALL ACCOUNTS which are past due (60 days). In the case of default on payment of the account, I agree to pay collection costs $75.00 and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balance. The parent/guardian who accompanies a dependant who receives treatment is responsible for their co-payment. Also, a processing fee of $35.00 will be incurred on returned checks for non-sufficient funds. (We may ask to see your driver's license).

Our office policy has a '24-hour working day notice' requirement for cancellations or re-schedules. Please notify us as soon as possible, since appointments are scheduled in advance. **Without prior notification a charge will occur for missed appointments, even if rescheduled**.

I have read the above information and understand that this information is applicable to any dependents and me.

Please list dependants, printed: ____

Responsible Party, printed: ____

Signature of Responsible: ____ **Date:**__________