FINANCIAL AND CANCELLATION POLICY

Thank you for choosing Greenland Advanced Oral Care as your prosthodontic health care provider. We believe that all patients deserve the absolute best dental care we can provide and that we won't allow insurance to dictate your dental care. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information before being treated by Dr. R. Graham Greenland.

FULL PAYMENT of the agreed upon terms are due AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS CARDS AND DEBITS CARDS.

REGARDING INSURANCE:

Greenland Advanced Oral Care does not participate with any insurance companies. However, we will submit the billing for you to your insurance carrier for reimbursement at the time of service. You are responsible for any balance left unpaid by the insurance carrier.

USUAL AND CUSTOMARY:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS:

Adult patients are responsible for full payment at the time of service. If you are unable to pay currently, be sure to inform us within 24 hours of your scheduled appointment.

MINOR PATIENTS:

The adult accompanying a minor and/or the parents or guardians are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved, credit card, or payment by cash or check at the time of services is verified.

PAYMENT PLANS:

Greenland Advanced Oral Care expects 50% deposit upon your agreement for scheduling treatment. The balance is due upon delivery of care and/or prosthetics. Our quote for treatment is all inclusive with the exception should there be any changes in your health, condition, or care requirements to complete your treatment. You will not receive additional charges unless discussed with you by provider.

1179 East Paris Ave., SE Suite 100 Grand Rapids, Michigan 49546

Phone: 616 -256-8770 Fax: 616-327-7452

PROSTHETICS:

Crowns, Dentures, bridges, etc., Failure by patient to return for the delivery of these items is subject to doctor time and lab fees charges. Full collection practices will be used to remedy any financial balance.

Signature: _____ Date: _____

MISSED APPOINTMENTS:

Unless cancelled at least 24 hours in advance, our policy is to charge for a missed appointment at the rate of $50 per hour of reserved doctor and/or hygienist time. We have the right to charge patient the full cost of their missed appointment. Please understand that missed appointment times are valuable to those patients that may find it hard to come to the dentist at other times. Please help us serve you better by keeping your scheduled appointments. Excessive cancellation and no shows will result in termination of our treatment agreement, and you records can be forwarded to another dental office. A copying fee of treatment records may apply.

COLLECTIONS:

This is a $50 returned check fee.

Any account that has not received a payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality of dental care in a relaxing and caring atmosphere.

I have thoroughly read and understand the practice Financial and Cancellation Policy. I understand and agree to the above policy. This policy is in effect for all appointments at Greenland Advanced Oral Care. Please acknowledge that you have had the opportunity to review this policy by signing below.

Signature: _____

Date: _____

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