**Michael T Guldan DDS PLLC**

**Written Financial Policy**

Thank you for choosing Michael T Guldan DDS PLLC. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

**~Cash, Check, Visa, Mastercard, Discover, Care Credit, Ally Lending, and United Medical Credit~**

Payment is due at the time of service. All insurance claims will be submitted on your behalf, however, the check will go to you as reimbursement. Michael T Guldan DDS PLLC requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be arranged.

**WE ARE NOT A PARTICIPATING PROVIDER. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Initial and Date)**

A surcharge of 5% will be added to your account if payment is not made at the time of service.

In addition, a finance charge of 1% will be applied if your balance isn’t paid in full within 30 days. If your balance isn’t paid within 90 days a charge of 12% will be added and you will be referred to an outside collection agency.

A fee of $50 is charged for patients who miss their appointment without notice or cancel more than two times in a calendar year, without 48 hours advanced notice, except in times of medical emergency or bad weather.

There will be a $50 charge for returned checks.

**Notice of Privacy Practice, HIPAA**

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy of the Notice of Privacy Practices.

**General Dentistry Consent Form**

I have read and understand the General Consent form for each of the treatments I may receive. If I have further questions, I understand that I may ask them at any time throughout my treatment. We will offer you a copy at your first visit or anytime you request one of any treatment completed.

We will offer you a copy of the financial policy and privacy practices at your first visit or anytime at your request.

Signature Date