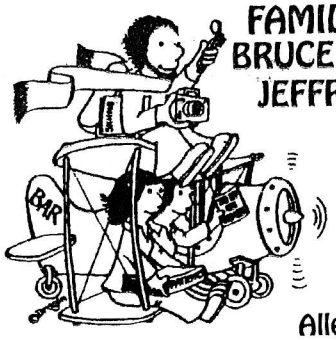

FAMILY DENTISTRY, P.C.
BRUCE ROSENBLUM • DDS
JEFFREY SEKERAK • DDS

313-383-3000
Fax: 313-383-1631

10501 Allen Road
Allen Park, Michigan 48101

Welcome to Family Dentistry P.C.

We are extremely pleased that you have chosen our office to serve your dental needs. Our staff is looking forward to helping you with any concerns that you may have as well help you maintain excellent dental health.

Besides staying in touch with the latest technology to bring our patients the best dentistry possible, we strive to keep our costs at a rational level. In an effort to keep fees reasonable and to continue to provide quality care, we maintain the following payment policy:

1.) Payment for all dental treatment is expected at the time treatment is rendered, if not, a $10.00 statement charge may apply.
2.) Cash, check, debit, and all major credit cards are acceptable methods of payment.
3.) Care Credit is available for qualified patients. This is a line of credit with several payment options.
4.) For treatment requiring multiple visits, ½ of the balance is to be paid when treatment is started, with the remaining balance due in full upon completion.
5.) Missed appointments without 24 hours prior notice may be subject to a $30.00 fee.
6.) For any returned check unpaid, there will be a minimum fee of $25.00
7.) There is a $39.00 fee for duplication (copying) of x-rays.

<u>For patients with dental insurance:</u>

Family Dentistry is happy to bill your insurance carrier. However, we do require payment for any uncovered services, deductibles, or co-payments on the date of your appointment. For more extensive dental treatment, you will be given an estimate of what your insurance company is expected to pay. Any estimated co-payment will be handled according to the above financial policy. While filing insurance claims is a courtesy we extend to our patients, ultimately all charges are your responsibility for the date services are rendered in the event your insurance does not pay what was originally anticipated.

I have read and understand the above Financial Policy.

_____ _____

Signature of Patient / Guardian (if under 18) Date

_____

Printed Name of Patient / Guardian