

Mason Family Dentistry

Responsible Party Registration (one per family)

Name of responsible party: _____

Birthdate: _____ Home Phone #: _____

Cell Phone #: _____ Work Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Person: _____ Phone #: _____

Do you have dental insurance? Yes or No Are all family members covered? Yes or No

Subscriber Name: _____ SS#: _____ DOB: _____

Employer: _____ Group #: _____

Insurance Company: _____ Insurance Phone #: _____

Additional dental insurance? Yes or No Are all family members covered? Yes or No

Subscriber Name: _____ SS#: _____ DOB: _____

Employer: _____ Group #: _____

Insurance Company: _____ Insurance Phone #: _____

Whom may we thank for referring you? _____

Other Family Members:

Spouse's Name: _____ Birthdate: _____

Cell Phone #: _____ Work Phone #: _____

Child's Name: _____ Birthdate: _____

Child's Name: _____ Birthdate: _____

Child's Name: _____ Birthdate: _____

Child's Name: _____ Birthdate: _____

Please read and sign the financial and cancellation policy on the reverse side - thank you.

FINANCIAL POLICY

We are committed to providing you with the best possible dental care. We also want to serve you in a manner which is as comfortable and pleasant as possible. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly discuss your proposed treatment, give you as detailed an estimate as possible in writing, and answer any questions that we can about your insurance. If you have dental insurance, we will assist you in receiving your maximum allowable benefits.

We cannot emphasize too strongly that the extent of your insurance benefits is defined in a contract between you, your employer and an insurance company. We are not a party to that contract. We had no input into any of the decision-making. As your dental care providers, our relationship is only with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that the services were rendered. We will help you by processing your insurance claim form and sending it in promptly. All co-pays will be collected at time of service. Payment can be made by cash, check or Visa/MasterCard.

For your convenience we offer a third party financing plan, *Dental Fee Plan by Capital One*, for treatment plans over \$300, with approved credit. Depending on the cost of your treatment plan, 3 and 6 month interest free plans are available.

I authorize the release of dental information necessary to process an insurance claim. I authorize payment of dental benefits to the provider for professional services rendered. I understand that when my dental insurance coverage excludes or does not fully cover services rendered, I am responsible for the account balance in full. In the case of default of payment, I will pay a \$20.00 collection fee, any legal interest on the balance due and attorney fees incurred to ensure collection.

CANCELLATION POLICY

We understand that things come up that are out of our control. It is our office policy not to charge for the first missed appointment, however in the future, if an appointment is failed or is cancelled with less than 24 hours notice, and we are unable to fill your appointment, you may be charged \$25.00. We will try our best to fill the appointment, the more notice we are given the better chance we will have filling the appointment time. With three failed or cancelled appointments within 18 months, you will be dismissed from our practice. You may obtain your records and x-rays for a fee of \$25.00.

Responsible Party Signature: _____ Date: _____

Mason Family Dentistry
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