John O. Leitner, DDS
575 Robbins Road
Grand Haven, MI 49417
616.842.2850
www.mymichigandentist.com

FINANCIAL AGREEMENT FOR JOHN LEITNER, DDS

Thank you for choosing John Leitner, DDS as your dental provider. This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Third party, extended payment financing is available through Care Credit, upon request and approval.

Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

Additionally, our practice will charge you for appointments that you do not keep and for appointments that you do not cancel with 48-hours notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

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Print Name of Patient or Responsible Party Date

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Signature of Patient or Responsible Party Date

PLEASE SIGN BOTH SIDES OF FORM!

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PAYMENT OBLIGATIONS AND COMPLIANCE

1. RELEASE OF PERSONAL HEALTH INFORMATION

I herby authorize John Leitner DDS to release personal health information (PHI) with legal limits of the Health Information Portability and Accountability Act (HIPPA) of 1996 to:

- Any third party responsible of paying or overseeing my medical care, including consulting physicians or hospitals
- Any outside peer review or auditing agency engaged by a third party payer
- To any person I have designated as my agent and/or patient advocate to act for me as permitted by state and federal law
- I understand that I may receive a progress note for delivery to my physician directly, and I assume all responsibility for doing so, including my own privacy.

2. NO SHOW AND CANCELLATION POLICY

I agree to contact John Leitner DDS in the event that I am unable to attend my scheduled appointment. If I do not call or contact John Leitner DDS within 24 hours to cancel my appointment and fail to attend, I will be charged a $25.00 No-Show fee per missed appointment. John Leitner DDS reserves the right to waive the fees for extenuating circumstances.

3. ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment of dental benefits to John Leitner DDS for all services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize John Leitner DDS to release all information necessary to secure payment by my insurance provider. A photocopy of this assignment is to be considered valid as an original.

____
Signature Date

____
Signature of parent/guardian/caregiver

PLEASE SIGN BOTH SIDES OF FORM!