

**MICHANOWICZ ENDODONTICS
814-696-1800**

FINANCIAL POLICY

FOR PATIENTS WITH DENTAL INSURANCE

Our experience with many dental insurance contracts reveal that misunderstandings most often occur concerning co-payment. Please read the statement below and sign.

DENTAL INSURANCE CO-PAYMENT

I understand my dental insurance may only pay a portion of my treatment, and my portion, or co-payment, and/or deductible is due at the time of treatment. My portion is only an estimate, if my insurance pays a lesser amount, it is my responsibility to pay the difference. I will either pay my co-payment and/or my deductible by Cash, Check, Money order, Master card, Visa, Debit card and Discover card, extended payments through my credit card, or use the six month interest free payment plan.

I authorize the release of any dental information necessary to process my claims, and agree to pay any portion of what my insurance does not cover.

SIGNATURE: _____ DATE: _____

I hereby authorize payment of my dental benefits to Dr. Andrew Michanowicz otherwise payable to me.

SIGNATURE: _____ DATE: _____