

Steven A. Beuligmann, D.D.S., Inc.
Cosmetic & Family Dentistry

We are committed to providing you and your family with the best possible care! If at any time you have a question regarding your proposed treatment options, fees, or insurance, please ask us. We are here to help!

Payment options include:

- Cash, Checks, Debit Cards, Visa, Master Card, and Discover (Sorry, American Express and corporate cards are not accepted)
- 5% cash courtesy may be applied
 - To those who pay in full with cash or check at time of service
 - On major services of \$1,000 or more
- Monthly financing is available through Care Credit (Please ask for additional details)

We are happy to handle the submission of your insurance claims for you; however, your estimated share of cost is due at the time of treatment. We must emphasize that as a dental care provider, our relationship is with you, not your insurance carrier. While the filing of insurance claims is a courtesy that we are happy to provide, all charges are the patient's responsibility. **WE ARE NOT ABLE TO GUARANTEE YOUR INSURANCE COVERAGE OR THE AMOUNT THEY WILL PAY.**

Our goal is to provide you with the highest quality of dental care, in a timely manner, with your considerations in mind. If you did not follow routine recommendations for preventive care, or proceed with needed treatment when advised, any necessary treatment for correction may now be more involved and comprehensive.

Appointment times are reserved exclusively for you. We do not double book like many other practices. Therefore the unkept appointment of one patient is a wasted opportunity to help another in need of care. For this reason we do require two full business days notice when unable to keep your reserved time. A fee of \$50 will apply for broken appointments except in the case of extreme emergencies.

Balances over 60 days may be subject to an interest charge of 1.5% or 18% pr. Annum. (1/03)
Delinquent accounts will be subject to collection costs.

We look forward to caring for you and your family. Thank you again for choosing our office to assist you in maintaining optimal dental health!

Patient Name _____ Date _____
(Please print)

I understand and agree that (regardless of insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

Signature _____ Date _____