

## Gentle Dentistry

Stephanie M. Busch-Abbate, DDS, PLC  
3048 W. Main Street  
Kalamazoo, MI 49006

### **Written Financial Policy**

Thank you for choosing Gentle Dentistry. Our primary mission is to enable our patients to achieve excellence in oral health and freedom from head and neck pain. We will make every effort to provide quality dentistry in a caring and pleasant atmosphere.

### **Payment Options:**

Full payment is expected at the time of service. You may choose from:

- Cash, check, credit card (Visa, MasterCard, Discover, and American Express), debit card, HSA, FSA
- Payment Plans from [CareCredit](#)



### **Insurance**

We may accept assignment of insurance benefits providing all paperwork and necessary information is complete. We do require that deductibles and co-payments be paid at the time of service. Your insurance policy is a contract between you, your employer, and the insurance company. You, the patient, have the ultimate financial responsibility for treatment. If any services are rejected by your insurance carrier, you are responsible for the fees. If we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits from your insurance carrier.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. The payments have nothing to do with the actual charges. The treatment recommended by our office is never based on what your insurance company will pay but what your dental health needs are; your treatment should not be governed by your insurance contract.

Please take the time to review your insurance contract thoroughly so we may best serve you and help you to receive the maximum benefits toward your dental health. As always, you may feel free to ask any member of our team for clarification on services, billing, and insurance.

### **Cancellation Policy**

We would greatly appreciate a **48** hour notice from any patient (or patient representative) should they need to reschedule or cancel an appointment. We reserve the right to apply a cancellation fee if this policy is not respected.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you need or want.

**I have read this policy, understand and agree to it.**

**Date** \_\_\_\_\_

**Signature** \_\_\_\_\_