Macy Family Dentistry

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Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

Therefore, we urge you, as the patient, to please check with your insurance company prior to any procedures being performed. *It is your responsibility to know your individual coverage.* This includes your deductible, calendar maximum and any frequencies that apply. Routine exams and cleanings are included in your calendar year maximum. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred.

You are ultimately responsible for inquiring with your insurance company regarding whether you are *in or out of network* with our dental office or any specialty doctors.

We can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. I am giving permission to use and disclose my health information in order to carry out treatment, payment activity and healthcare options.

Please remember, your insurance policy is between you and your insurance company and *not with the insurance company and your dentist.*

Macy Family Dentistry does require payment in full of your *estimated copayment* at the time of service. We accept MasterCard, Visa, American Express, cash and checks. If you are in need of an extended finance option, we also work with CareCredit, who offers 12 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

Patient Name (please print) _____
Signature _____
Date _____
Witness _____
Date _____

Consent to Discuss Treatment

I authorize Macy Family Dentistry to discuss my account details, treatment plan options and any related matters regarding my dental health with the following individuals I have listed below;

Name: _____ Relationship: _____
This authorization will remain on file unless rescinded by the patient in writing.

9485 MENTOR AVE, STE 112 | MENTOR, OH 44060 | PHONE: (440) 255-8133