

**Financial Policy Agreement**  
**Learman Dental**

4141 Shrestha Dr.  
Bay City, MI 48706  
989-667-5630

117 North Forest St.  
Standish, MI 48658  
989-846-9545

Patient First, Middle, Last Name: \_\_\_\_\_ Preferred Name \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security# \_\_\_\_\_  
Gender: *Male Female* Marital Status: *Single Married Divorced/Separated Widowed*  
Home Phone# \_\_\_\_\_ Cell Phone# \_\_\_\_\_ Email \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Responsible Party (if child name of parent): \_\_\_\_\_  
Responsible Party Social Security # \_\_\_\_\_ DOB \_\_\_\_\_  
Name of Spouse \_\_\_\_\_ DOB \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_  
Subscriber ID# \_\_\_\_\_ Employer \_\_\_\_\_

For those patients who are covered by private insurance, we are pleased to extend the courtesy of billing your insurance company for you. In order to provide this service for you, we must have complete insurance information and confirmation of your coverage. We ask that you fill out all forms, which will give us the necessary information. It is our policy that anything not covered by insurance is to be paid for at the time of service. Our office does not guarantee the patient's insurance company will pay. We ask that you read YOUR policy to be sure you are fully aware of any limitations of benefits provided.

If you do not have dental insurance, payment is expected at the time of service. For more extensive treatment, we will make financial arrangements to be paid within a reasonable time period. We accept MasterCard, Visa, Discover, American Express, and Care Credit. Care Credit offers a no interest, minimum balance plan for various terms and amounts.

We respect your time and ask that you reciprocate. When we schedule an appointment for your treatment, we are reserving that time specifically for you, rendering that time unavailable to any other patient that may need our services. Please have the courtesy to inform us in advance if you are unable to keep your specific appointment time. **Unless cancelled at least 24 hours in advance, our policy is to charge \$75.00 per missed appointment.** Please help us to serve you better by keeping scheduled appointments and arriving on time.

I understand and agree to honor my financial commitment to Dr. Michael Learman as outlined above. I hereby authorize Dr. Michael Learman to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Signature of patient/responsible party

\_\_\_\_\_  
Date