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Phone: 517-546-9190
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Our Financial Policy

Thank you for choosing Ryan Breasbois, DDS PC as your dental care provider. We are committed to providing you with the best possible care. If you have dental insurance, we would like to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our financial policy. Please understand that payment of your bill is considered part of your treatment. We require that you read and sign the following statement prior to any treatment. Full payment is due at the time of service. We accept cash, checks, Visa, and Mastercard.

Regarding Insurance

If you provide us with complete insurance information, we will be happy to process your insurance claim for you. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we require that you pay your copayment and deductibles at the time of any and all services. We will gladly discuss the cost of your proposed treatment and answer any questions that you may have. Please realize that not all services are a covered benefit in all contracts. We must emphasize that as Dental care providers, our relationship is with you, not your insurance company, while the filing of insurance claims is a courtesy we extend to all our patients.

Usual & Customary Rules

Our practice is committed to providing the best treatment for our patients and the rates we charge are usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments

Unless canceled at least twenty-four hours in advance, our policy is to charge for missed appointments at the rate of $40.00 per missed visit. Please help us serve you better by keeping scheduled appointments. Thank you for understanding our financial policy. Please let us know if you have any concerns.

I have read the financial policy. I understand and agree with the financial policy.

Signature of patient or parent if a minor **Date**

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