

# Birmingham Center for Cosmetic Dentistry

## Mitchell S. Milan, D.D.S.

555 S. Old Woodward, Ste. 701 | BIRMINGHAM MI, 48009 | (248) 644-2136

### Written Financial Policy

Thank you for choosing Mitchell S. Milan, D.D.S.. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

#### **Payment Options:**

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- NO INTEREST<sup>1</sup> Payment Plans<sup>2</sup> from CareCredit
  - o Allow you to pay over time with NO INTEREST<sup>1</sup>
  - o Convenient, low monthly payment plans<sup>2</sup> also available
  - o No annual fees or pre-payment penalties

Please note:

Mitchell S. Milan, D.D.S. requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For larger, more comprehensive treatment plans of \$400 or more, a 50% deposit is required to secure your initial treatment appointment. For procedures that require multiple appointments, full payment is required prior to the final placement appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and provide you with the documentation you need to receive reimbursement for your treatment. It is important to note that your insurance is a contract between you and the insurance company and we cannot guarantee that the information we give you is accurate and any balance the insurance does not pay is your responsibility.

A fee of \$75 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

Mitchell S. Milan, D.D.S. charges \$45 for returned checks.

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

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Patient, Parent or Guardian Signature

Date

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Patient Name (Please Print)

<sup>1</sup>If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

<sup>2</sup>Subject to credit approval