

**Dan W. Rajek, D.D.S., S.C.**

301 East Second St.

Merrill, WI 54452

(715) 536-2282

www.danrajek.com

**OUR OFFICE POLICY**

Welcome to our office. It is our intention to make sure your visit is as comfortable as possible. Please take the time to look over our office payment policy. If you have any questions, please do not hesitate to ask.

- Please provide us with your dental insurance card and we will gladly submit your claims for you.
- Our practice is committed to providing the best treatment for our patients. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Dr. Rajek uses resin (tooth colored) fillings as opposed to amalgam (silver) fillings on permanent (adult) teeth as they bond to the tooth, and look so much nicer. Keep in mind that not all insurance companies cover these types of fillings. Regardless of insurance coverage you are ultimately responsible for payment.
- Balances over 60 days left unpaid are charged 1 ½% interest per month, 18% annually.
- On the day of service, all deductibles and co-payments MUST be paid.
- Patients without insurance MUST pay in full on the day of service. Payment may be made by cash, check, Visa, MasterCard, Discover, American Express, or CareCredit.
- Unless cancelled at least 24 hours in advance, our policy is to charge a normal office visit for missed appointments.

Patient's Signature \_\_\_\_\_  
(Parent's Signature if patient is a minor)

**Authorization To Pay Benefits To My Dentist**  
**Authorization To Release Dental Information To Insurance**

This signature is my written authorization to pay Dr. Rajek any dental benefits due and payable by my insurance company to apply to my outstanding balance. My signature also states that I understand the above office policy and I will be responsible for any outstanding balances my insurance does not cover. My signature also authorized the release of dental information required by my insurance company regarding claims submitted.

Patient's Signature \_\_\_\_\_  
(Parent's Signature if patient is a minor)