

Kurt Weisenfels, DDS, PC
20 West Lockwood Ave
St. Louis, MO 63119
Phone: 314-961-3244

OUR OFFICE POLICY

GENERAL

Thank you for choosing our practice as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read, and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor. FULL PAYMENT IS DUE AT TIME OF SERVICE. Patients with dental insurance will be asked to pay their "out of pocket portion" at time of service.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, Discover and American Express.

REGARDING INSURANCE

Fees are estimates only, are valid for 30 days from the date shown above and are subject to revision. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER

All ESTIMATED portion and deductibles are due prior to or at time of treatment. In the event that YOUR insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph.

USUAL AND CUSTOMARY RATES

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

ADULT PATIENTS

Adult patients are responsible for full payment (or the out of pocket portion) at time of service.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment (or the out of pocket portion). For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved; Visa/MasterCard, or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS

Unless canceled, at least 2 business days (Monday-Thursday) in advance, our policy is to charge for missed appointments at the rate of \$35.00 to the full amount of the scheduled visit. Please help us serve you better by keeping scheduled appointments.

INTEREST

We reserve the right to charge interest in the amount of 12% per annum as provided by state law. Thank you for understanding the Financial Policy.

Financial Agreement

- I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance.
- I understand that I may incur a 12% per year finance charge if my balance goes beyond 90 days.
- I assign dental benefit payments to be paid directly to Dr. Weisenfels from my insurance company.
- I give permission for my dentist and his/her clinical team to take any necessary diagnostic films, photos, or study models to properly enable complete diagnosis and treatment.
- I understand that in the event that my account goes to collections, I am responsible for the costs of collecting the balance owed, including collection fees, attorney fees, and any incurred court costs that may apply.