

FINANCIAL POLICY

Thank you for choosing Dr Wallingford as your dental care provider. We are committed to providing you excellent care and payment of your bill is part of successful treatment. Please read our Financial Policy and acknowledge your agreement with your signature and date below.

REGARDING INSURANCE

As a service to our patients, we will prepare and submit your insurance claim form and accept assignment of insurance benefits. It is ultimately the patient's responsibility to verify coverage and charges with the insurance company, as well as to verify that this office has the correct insurance information, including plan information.

At the time of your appointment, you will be expected to pay your deductible as well as any portion of the treatment fees that we estimate will not be covered by your insurance policy. Because of insurance policy changes and/or necessary changes in treatment plans, your dental coverage may vary from this estimated treatment calculation. **Please be aware that our estimate for your treatment is only that: an Estimate.** There may be a balance on your account after insurance pays, for which you are responsible.

Our office will submit your claim to your insurance company twice if necessary. Additional submissions are the patient's responsibility. **If your insurance company has not paid the full balance of the claim within 60 days from treatment date, you will be responsible for paying the balance.** *Please remember that your insurance is a contract between you and your insurance company. Our office is not a party to the contract.*

ACCOUNTS

A late fee of \$25.00 may be assessed to accounts with balances outstanding for 60 days from treatment date. In the event of non-payment, the responsible party agrees to pay all the costs of collection including but not limited to attorney fees, court costs, collection agency fees, etc.

If your check is dishonored or returned for any reason, you expressly authorize our office to electronically debit your bank account for the amount of the check, plus a \$25.00 processing fee. Your use of a check for payment is your acceptance of this agreement and its terms.

MINOR PATIENTS

The parent/guardian accompanying a minor is responsible for payment of deductibles or any co-pays at the time of service. Any arrangements between ex-spouses for payment need to be handled between them. Our office will not bill separately in those cases.

MISSED APPOINTMENT FEE of \$50.00 if less than 24hours notice given.

I have read and understand the financial policy of this practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient/Parent/Guardian_____ Date_____