Randy L. Wolff D.D.S., Inc.

Excellence In Dentistry

Financial Policy

Thank you for choosing us to care for your dental health! We look forward to caring for your smile and are committed to your treatment being successful. We do this by providing the same high quality care for you that we would for our closest relatives and ourselves. Please understand that payment for your services is considered part of your treatment. Our goal is to keep costs as low as possible which means that we are unable to bill patients for services.

In order to provide quality care, we must be able to treat our patients without regard for insurance or the limitations they establish. Therefore, treatment is diagnosed based on your dental health needs and not on your insurance benefits. We will "guestimate" what your insurance plan may pay to us based on your eligible benefits.

For Uninsured Patients

1. Payment is due at the time of treatment.
2. We accept cash, check, Visa, MasterCard, Discover, American Express and Care Credit.
3. There is a 5% discount available when treatment is paid for in full with cash or check at the time of service.
4. Balances over 60 days will accrue finance charges at 1.8% monthly.
5. Balances over 90 days will be sent to collections.

For Insured Patients

1. Payment of the patient portion is due at the time of treatment.
2. We accept cash, check, Visa, MasterCard, Discover, American Express and Care Credit.
3. Balances over 60 days will accrue finance charges at 1.8% monthly.
4. Balances over 90 days will be sent to collection.
5. As a courtesy to our insured patients, we will submit claims to your carrier and accept payment directly from them. Please be aware that your insurance carrier is responsible to you, as you are responsible to us. If you insurance does not pay their portion within 90 days, the full balance then becomes the patient's responsibility.
6. No one at this office is authorized to guarantee your insurance covered or benefits, as we are not agents for your insurance carrier.

For Aetna Access (a discount plan), payment in full is due at the time of service

I understand that my insurance company may not pay for Posterior Composite restorations. They may, however, pay for Amalgam restorations and by signing this financial policy, I am fully aware that I will be responsible for payment of the different in price.

I have read this financial policy and agree to be fully responsible for all fees regardless of insurance coverage. I authorize the release of all necessary information to my insurance company. I understand that if my account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for legal fees, collection agency fees, finance charges and any other expenses in collecting my account.

Signature____ **Date**______________

Print Name____

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