Richard Wetherill III DDS
Financial Policy

Patient Name (print): _____

Date of Birth: _____

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

Payment is due at the time services are rendered. For your convenience, our office accepts cash, credit cards, personal checks or care credit.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for up to 50% of any collection and/or legal charges incurred.

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payments directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or care credit at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- It is your responsibility to notify our office of any changes in your employment or insurance coverage prior to your appointment. As such, you should be prepared to provide your insurance card or information prior to each visit with our office.

Appointment Policy

- When we schedule an appointment, we are setting aside dedicated time specifically for you, and we will make every effort to remind you of your appointment in advance.
- We only ask that, should you need to change your appointment, kindly give our office 24 business hours' notice. This ensures that we can adequately serve our other patients who may want/need this time.
- Any patient who fails to arrive for their reserved appointment(s) at the scheduled time or who cancels without 24 hours' notice may be charged a **missed appointment fee of $50**. _____(initial) Please note this fee is NOT covered by any dental insurance.
- We understand that unexpected circumstances may arise and as such will waive this fee when necessary at management's discretion.
- Please also note that, should you arrive more than 15 minutes late to your scheduled appointment, we may not be able to keep the appointment as planned as it may run into another patient's scheduled appointment time. If we have to reschedule due to your tardiness, the appointment will be treated as a missed appointment.
- After 3 or more missed appointments, your ability to schedule future visits with our office may be affected and/or you may be dismissed from our practice.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due, and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge, and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient/Guardian Signature **Date**