

Financial Policy

In order to provide you with the highest quality dental care, we provide our patients with an estimated fee and arrange for a payment schedule. Please review the following options:

- 1. Co-payments from patients with insurance coverage are expected at the time of treatment.
- 2. Patients without insurance coverage are responsible for payment in full at the time of services rendered.
- 3. We accept all major credit cards: Visa, MasterCard, American Express and Discover. For your convenience a credit card may be kept on file for any agreed upon charges.
- 4. Interest free extended payment plans are available based on credit approval thru Care Credit.
- 5. A third party fee will assessed once the account is turned over to collections. You will be responsible for any and all third party fees.

Signature: _____ Date: _____

Insurance

Providing accurate insurance information will allow us, as a courtesy, to file your claim in a timely manner and to maximize your benefits, but be advised this is an agreement between you and your insurance company. However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment. Ultimately the patient is responsible for all fees for services rendered. Because we cannot guarantee your benefits it is in your best interest to familiarize yourself with the terms of your policy.

I understand that I am responsible for estimated deductibles and co-payments at time of service. I understand that I am responsible to notify Wyoming Family Dentistry of any changes to my insurance policy. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ Date _____

Cancellation Policy

Your dental needs are a priority therefore, it is important that you keep your dental appointment to maintain optimal dental health. However, we understand there are times when an appointment has to be changed. In order to accommodate other patients and to avoid any unnecessary cancellation fees we require a 24-hour cancellation notice.

Acknowledgement of receipt of Notice of Privacy Practices

(Please read included paper of Privacy Practices.)

I, _____, have received a copy of the office's Privacy Practices.