THE DENTAL SHOPPE

FINANCIAL POLICIES

In order to enhance communication and promote understanding regarding this office's Financial Policies, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. Please feel free to ask us about any questions or concerns you may have. Thank you!

- **Insurance:** At The Dental Shoppe, we are happy to bill both primary and secondary insurances for you. **We feel it is important to explain, however, that insurance companies cannot guarantee dental benefits to us, and all *estimates* for your portion due are truly only an *estimate*.** It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portions due; however, if the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment would be expected within 30 days of receiving a statement. Insurance is never a guarantee of coverage.

- **Patient Payment:** The patient portion due for services rendered is expected at the time of service unless *previous* arrangements have been made with the office. We accept cash, checks, and all major credit cards.

- **Financing:** We have financing available through Care Credit. If you have an interest in this option, please consult with the office prior to the date of scheduled treatment.

- **No Shows/Missed Appointments:** We request notice to cancel or reschedule an appointment at least 24 hours in advance. If appropriate notice is not given, a charge of $75 may be assessed to the patient's account.

- **Refunds for Unfinished Treatment:** If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office.

- **Credits on an Account:** If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.

- **Collections:** On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collections agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorneys fees, and any other costs that may be incurred to enforce collection of any amount outstanding.

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Dr. Winnicki all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that payment is due at the time of service. If working with insurance, I understand that my ESTIMATED portion is due at the time of service.

Patient Name:_____

Financially Responsible Person:_____

Signature of Financially Responsible Person:_____Date:_____