Woodholme SMILE CARE
YOUR HOME FOR DENTAL IMPLANTS AND ADVANCED DENTAL CARE
NEW PATIENTS WELCOME

Financial Policy

PATIENT INFORMATION

First Name		Last Name		Birth Date	

Taking care of you and your family is our highest priority. Our team is committed to your overall health and the success of your treatment. Just as we are committed to providing you with the very best dentistry has to offer, so are we committed to making dentistry financially comfortable for you and your family. That is why, when it comes to talking about finances, our goal is to ensure you have a complete understanding of your estimated financial responsibility and the payment options available to you at Woodholme Smile Care (WSC).

ABOUT OUR FEES

Just one of the many things you will come to expect from us at WSC is your written financial estimate. We never perform, before we inform! Please understand that we strive to provide you with the best written estimate of your expected fees. Because dentistry is a science, the need for an alternative or additional procedure(s) sometimes arises during an appointment. Should this occur, we will discuss any additional estimated costs with you prior to beginning treatment.

YOUR INSURANCE SAVINGS

Dental insurance was designed to assist you with your dental expenses, not to offer comprehensive coverage like most medical plans. By maximizing your benefits, we are able to save you money. We will accept assignment of benefits and file your insurance claims. It's hassle free at WSC! It is important, however, that you understand that your benefits are negotiated between your employer and insurance company. Therefore, some, or perhaps all, of the treatment you choose to have completed may be non-covered services under the policy your employer has selected. We will always provide you with a **written estimate** of your expected fees. Any procedures not covered by your insurance benefits are your responsibility.

MISSED OR CANCELLED APPOINTMENTS

Please help us serve you and our other patients better by keeping your scheduled appointments. Appointments that are missed or changed with less than 24-hour notice, during normal business hours, are then unavailable to other patients.

A fee of $50-hour will be charged for appointments that are missed or changed with less then 24-hour notice.

PLEASE PICK YOUR PLAN

- ❑ **Premium Plan: We know that not all of our patients enjoy insurance benefits. *For those without insurance, we extend an 8% courtesy on all services for payment in full at the time of service.***
- ❑ **Silver Plan: We want you to know that seniority matters to us! *We extend a 10% courtesy to our 65+ patients that have no dental benefits when they pay in full by cash or check at the time of service.***
- ❑ **Insurance Savings Plan: We are happy to assist you in any way we can with your benefits. We will submit your claims and work with your insurance company to maximize your benefits**
- ❑ **Predicable Payment Plan: Payments may be perfect for you and we may be able to help. We can make special arrangements based on your needs. Please ask our Financial Coordinator for assistance. She would be happy to help!**

I have read and fully understand my financial obligations. I understand that any insurance estimate given is not a guarantee of actual insurance payment and/or coverage. I understand that any insurance claim not paid in full over 60 days will become my responsibility. Additionally, by signing this form I authorize WSC to process credit card transactions by me either by mail or phone and I authorize my credit institution to pay. I understand that in the event my account becomes delinquent, I will be responsible for any billing charges, finance charges, collection fees, legal fees and/or other charges incurred to collect this account. I assign WSC all insurance benefits directly to the practice. 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. WSC may use my health care information and may disclose such information to my insurance companies and their agents for the purpose of obtaining payment.

FORM COMPLETION

I certify that I have read, understood and agree to these terms.

Signature of	❑ Patient	❑ Legal Guardian	❑ Parent	❑ Agent Under Durable Power of Attorney
Printed Name	*First Name*	*Last Name*		

Signature of Patient, Parent or Guardian		**Date**	