Michael D. Wasco DDS LLC

Dental Financial Policy

I understand that all dental services furnished to me are charged directly to me and that I am responsible for all charges. **A late charge of $44 will be added for all outstanding balances 60 days after services are rendered. A 5% Balance Finance Charge will be added monthly to the balance** I agree that in the event that this office has an outstanding balance on my account for services rendered, that I shall be required to pay all costs including attorney's fees incurred in the recovery of the balance. I grant my permission to you or your assignee, to contact me at home or work to discuss matters related to collections of any account balance.

Optional Payment Terms:

1. **Co-payment at time of service**: You pay your estimated co-payment at time of service. We will bill you for any remaining balance after we receive your insurance payment or ninety days after treatment.
2. **Smile Bright Discount Program:** Smile Bright is a yearly dental plan we offer to individuals that do not have access to dental insurance in order to reduce the cost of excellent dental care. Payment options are available. Ask us for more information.
3. **Pre-Payment**: We collect a payment **monthly** before your appointment and once your account balance is high enough for the co-payment we will schedule the needed treatment.
4. **Care Credit: upon approval**, an interest-free term loan (6 to 12 months) is available. Please ask for more information.

We charge $25 for all returned checks

We depend on you, so we require a 24 hr notice for cancellations, failure to do so will result in a broken appointment.

_____ **No Show or Broken appointments will result in a $25 per half hour charge.**

A minimum of a **$40 reservation** for your next appointment might be required prior to rescheduling if we have frequent cancellations for any reason. This reservation will be credit on your account. In case of a short term cancellation, your $40 reservation will be non-refundable.

In the event of an **after hours** emergency a **$150 emergency fee** will be charged for established patients in addition to the necessary treatment fees.

I have read the above conditions and agree to their content.

Print Name:_____ Date: _____

Patient/Parent Signature: _____

Insurance Financial Policy

Rev 8

Effective 11/21/2019

Insurance Primary (please provide copy of card)

Subscriber Name:	Relation to patient	Subscriber DOB: / /
Subscriber SSN/ID:	Group Number:	
Ins Company Name:	Ins Phone:	

Insurance Secondary (if any)

Subscriber Name:	Relation to patient	Subscriber DOB: / /
Subscriber SSN/ID:	Group Number:	
Ins Company Name:	Ins Phone:	

Initial:

_____ ▪ Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans are not guaranteed to pay for all of your dental care. They are only meant to assist you in reducing some of your costs.**

_____ ▪ We currently accept all private care insurance plans. This means that we work with literally hundreds of companies. Although we maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" upon your request prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you a better estimation of out of pocket expense.

_____ ▪ Our office is committed to helping you maximize you insurance benefits. We can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. **Your estimated patient portion must be paid at the time of service.** As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment. **After 60 days, you are responsible for the entire balance, paid- in- full. A $44 late fee will be applied and a 5% Balance Finance Charge to all monthly statements thereafter.**

_____ ▪ I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Michael D. Wasco DDS LLC all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions

Print Name:_____ Date: _____

Patient/Parent Signature: _____