SHERIDAN Wyo DENTAL

FINANCIAL POLICY

Thank you for choosing our office to be your dental health care provider. We are committed to providing you with excellent dental care. Our financial arrangements are based on an honest discussion of recommended treatment options, respective fees, and the financial capabilities of our patients.

Payment: Payment in full is due at the time of service unless prior financial arrangements have been made. We offer several payment options:

- Cash
- Check
- Visa, MasterCard, Discover
- Monthly payment plan in accordance with office credit guidelines

Insurance: As a courtesy, we will submit a claim to your insurance carrier. Because insurance policies vary greatly, we can estimate your coverage in good faith but cannot guarantee it. All deductibles must be paid at the time of service. For most dental procedures, your insurance will cover only a portion of the treatment. Your co-payment (the portion not covered by your dental insurance) is due at the time of service. *Regardless of your insurance status, you are ultimately responsible for timely payment of all treatment received.* Since your policy is a contract between you and your insurance company and/or employer, we cannot assume responsibility for coverage or other determinations made by your insurance company.

Missed Appointments, Tardiness, & Cancellations: Your appointment time is reserved specifically for you. If you are late, we might not be able to accommodate you. Please call before a late arrival so that we can determine if your appointment needs to be rescheduled. We reserve the right to charge a fee for all missed appointments or cancellations without a 24- hour notice. An answering machine is available for messages left after hours.

Service Charges: A finance charge of 1.5% per month (18% annual percentage rate) or a monthly statement fee may be assessed to accounts with balances outstanding 60 days past the treatment date. You are responsible for any and all fees relating to the collection of your account.

Pretreatment Estimates: Fees quoted for treatment will remain in effect for 90 days and are thereafter subject to change without notice. In the event that clinical conditions warrant a modification in treatment, you will be notified about the changes and associated fees prior to your treatment.

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 policies. Significant costs are incurred in carrying our patients' accounts. To control costs and minimize fees, it is necessary to adhere to this policy.

Consent: I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay any dental benefits directly this dental office. It is understood that this executed copy of the Financial Policy shall also cover any of my dependents who are patients of this dental practice.

Patient Name or Responsible Party (please print): _____

Patient/Resp Party Signature: _____Date:_____