WALSWORTH
FAMILY DENTISTRY, P.C.
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Financial and Administrative Policies

Thank you for choosing our office for your dental needs. We are committed to providing you with excellent care and convenient financial arrangements. To confirm your understanding and agreement with our policies, please read and sign. We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Payment

Your estimated co-payment, coinsurance, unsatisfied deductible, or charges for non-covered services is due at the time of your visit.

We accept the following forms of payment:

a) Cash, Check, Visa and MasterCard.

For treatment plans over $500 we offer the following payment options (subject to approval)

b) In house three payment plan via credit card
c) Two payment option for major procedures such as bridges and dentures. 50% payment is required at the impression appointment and 50% at the seat appointment.
d) Care Credit third party payment plan, which upon approval, is interest-free for up to twelve months.

For larger treatment plans over $1500 or if you have a history of no-showing for appointments, a deposit of 50% of the treatment plan may be required to reserve your initial appointment.

If there is credit on your account a refund check will be issued for amounts in excess of $20.00. For amounts less than $20.00 the credit will remain on your account. If there is a balance on your account at the conclusion of your treatment plan a bill will be issued.

Change of Information

If you have a change of name, address, telephone number, or insurance, please notify us and we will update your information immediately. Failure to do so will result in errors in insurance estimation and appointment confirmation.

Service charges

Checks that are returned to our office from your financial institution are subject to a $30.00 returned check fee.
Outstanding balances older than 30 days will be subject to finance charges at the rate of 1.5% monthly.

Delinquent accounts

Outstanding balances over 90 days will be referred to a collection agency and will be subject to any additional collection fees.
Patients with outstanding balances on their account past 30 days will be seen on an emergency only basis until resolution of your bill.

Broken appointments

A specific amount of time is reserved especially for you. If you must change your appointment we request at least 24 hours notice. Repeated late cancellations or appointment failure will be subject to a $30.00 cancellation fee (emergencies are an exception).
A non-refundable deposit may be required to reserve future appointment time with our care providers.

Insurance

Our office is committed to helping you maximize your benefits. Insurance policies vary greatly. Therefore, owing to the complexity of insurance contracts, we can only estimate in good faith, not guarantee coverage. At your request, we can provide you with an estimate of your insurance coverage or preauthorize treatment with your insurance provider.
We accept assignment of benefits from most insurance companies. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 90 days, the balance will be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. This is not a reflection on the necessity or advisability of that treatment.
Your insurance is a contract between you and your insurance company. We will assist you in obtaining the maximum benefit from your policy, but we are not a party to that contract. It is your responsibility to know and understand your contractual obligations as an insured person under your specific contract.

Treatment plans

We require signed treatment plans prior to treatment. This provides you with an estimate of costs and constitutes your consent to perform the specific treatment. Treatment plan fees are honored for 90 days from the date of signed agreement.

Fluoride treatments

Patients to age 16 will receive fluoride treatments every six months, unless a parent/guardian request differently. If your insurance coverage differs from this, you will be responsible for the payment.

HIPAA Considerations

Due to health privacy laws we are limited in our ability to discuss treatment and payment with anyone except the patient. If you are anticipating payment by a parent, spouse, child, or other party, please recognize that we cannot make arrangements with them or discuss your treatment without your express consent. We will happily do this at your direction, but you as the recipient of the treatment are ultimately responsible for payment.

Financial Consent

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

The patient (or responsible party) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement

Signature of Patient or Responsible Party:_____

Date:_____