FINANCIAL POLICY

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable.

Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health.

For our patients with insurance, please understand that your insurance policy is a contract between you and your insurance company. As a courtesy to you, we can help you obtain the appropriate benefits from your insurance carrier, however we cannot guarantee any estimated coverage, and ultimately you are responsible for the payments on your account. Please know that we will do everything possible to see that you receive the full benefits of your policy.

PAYMENT OPTIONS AND POLICIES:

We accept the following forms of payment: Cash, Check, Discover, Visa and MasterCard. In addition, we offer CareCredit, a patient payment program offering a full range of No Interest and Extended Payment Plans upon approval. Returned checks are subject to a $25.00 fee.

Payment for services is due at the time services are rendered unless prior arrangements have been made. We would be happy to discuss our charges and how they relate to your particular situation. Please feel free to contact our staff at any time to discuss any financial questions that you may have.

DENTAL OFFICE INFORMED CONSENT

It is important to our office that you understand your rights as a patient. We would like you to recognize that you, the patient, have the right to accept or reject recommendation treatment. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Make sure you discuss potential benefits, risks, and complications with Dr. Woolsey.

CONSENT

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I authorize Dr. Woolsey and his staff to perform diagnostic procedures and treatment as may be necessary for proper dental care.

Patient Signature (*or parent, guardian*):__***to be signed electronically in the office***___ Date_____

☐I give my permission to take a picture of my child for displaying their pictures on the Good Brushing Club Board.