Insurance and Financial Policy

Please initial each line indicating that you have read and understand the financial policy, then sign at the bottom.

1. _____ Dental care is provided for the patient, not the insurance company. We will help prepare and file dental insurance claims, assist in making collections from insurance companies, and credit any funds received to your account. However, financial responsibility rests with you.

2. _____ Dental insurance will not cover the total cost of your treatment. Please understand that the amount of benefits paid by your policy is a predetermined arrangement between you and your insurance company; it is not possible for us to know all the limitations of your policy. It is your responsibility to be familiar with the terms and conditions of your benefits. For your convenience, we will estimate the amount that your dental policy will NOT pay. This is just an estimate. We cannot increase the benefit beyond what your agreement allows. The insurance agreement does not consider what is in your best interests and should not be used to determine your course of treatment. After your insurance company pays, you are responsible for any unpaid balance. We will ask you to pay your estimated portion and any copays at the time of service. For larger treatment plans, payment may be required prior to scheduling.

3. _____ We can preauthorize your treatment with your insurance company. This can result in delays of 4-6 weeks if your insurance company is slow to respond. A lengthy delay in treatment may not be in your best interests.

4. _____ Oral health can change over time. Therefore, treatment estimates are valid for 6 months after your last examination.

5. _____ A finance charge of 18% a month will be added to your account if payment has not been received in 60 days. This should allow adequate time for you to see that dental benefits have been paid.

6. _____ Appointments are reserved specifically for you and often cannot be filled on short notice. Therefore, appointments cancelled less than 48 hours in advance, or missed appointments may be subject to a missed appointment fee of $125 an hour, depending on the length of the reserved time.

7. _____ Accounts not cleared within 90 days without prior financial arrangements may be referred to a collection agency at our discretion.

8. _____ Cash, check, Visa, Mastercard, Discover, American Express, and CareCredit are all acceptable forms of payment.

9. _____Returned check fee is $25, payable by cash or credit card. This will be applied to your account in addition to the insufficient funds amount. Following a returned check, we may choose to place you on a cash only basis.

In consideration for professional services rendered to me or to my minor child or ward, I agree to pay the fee charged for dental services provided by Dr. Baker and/or the associates and staff of Wellness BioDentistry at the time the service(s) are rendered. I authorize my insurance company to make payment directly to Wellness BioDentistry for services rendered and agree to pay any unpaid balance.

I grant my permission to Dr. Baker and/or the associates and staff of Wellness BioDentistry to use any form of communication at home or at work, to discuss matters related to this financial policy. I agree to let this office leave messages concerning appointments and/or results on my answering machine, email, text messaging, or with a family member.

I authorize Dr. Baker and/or the associates and staff of Wellness BioDentistry to release financially identifiable information and treatment descriptions and information, either electronically, by fax, by text, by email, or in paper form to my insurance carrier or any related parties that require such information be submitted.

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Signature of patient or parent/guardian Relationship to patient Date