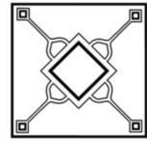
WATERFORD FAMILY DENTAL



FINANCIAL POLICY AND RESPONSIBILITY AGREEMENT

The following explanation is intended to give you, the patient, a better understanding of our financial policy. We require you to read and agree to sign this policy prior to the start of any treatment with Waterford Family Dental.
After the initial evaluation, the doctor will provide you with an explanation of his findings, a detailed treatment plan, an estimate of the expense of the proposed treatment and answer any questions that your may have.

FOR PATIENTS WITH DENTAL INSURANCE:
Our financial coordinator will be happy to assist you with information regarding insurance filing. If you have dental insurance, it should be understood that this is an agreement between you and your insurance company and is a method of reimbursing the patient for fees paid by the patient to the doctor. It is not a substitute for payment. The patient is responsible for full payment of all charges on his/her account. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance. Waterford Family Dental will assist you with obtaining pre-certifications for dental procedures if necessary. It remains your responsibility and obligation to verify insurance coverage and assume responsibility for payment of any and all procedures.

FOR PATIENTS WITHOUT DENTAL INSURANCE:
50% of the treatment cost must be paid prior to starting treatment. A payment plan to pay the remaining balance can be scheduled with our financial coordinator. We offer a 10% cash discount for payment in full at the time of scheduling treatment.

OUR SERVICES MAY BE PAID FOR AS FOLLOWS:

1. We accept Visa, MasterCard, Discover, American Express, CareCredit, personal checks and cash.

2. CareCredit ® is a credit company that will finance your dental work with approved credit. This will allow you to complete your dental work without delay and make relatively small monthly payments. Some of the plans, depending on the amount and length of time financed, provide a no interest, same as cash benefit. Our financial coordinator is happy to assist you with any information you may need and provide you with the appropriate application form.

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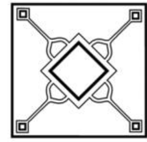

RESPONSIBILITY AGREEMENT:
I hereby agree to pay all amounts due on my account as service is provided.
I fully understand that I am financially responsible for all charges on my account whether or not they are covered by and paid for by my insurance company. If there is a balance due on my account after receipt of insurance payment, I agree to pay the full amount of the balance within 10 days of receipt of the billing statement.
If no insurance payment is received after 60 days of filing of my insurance, I agree to pay the full amount of the charges due within 10 days of receipt of the billing statement.

I HAVE RECEIVED THE ABOVE FINANCIAL POLICY AND AGREE TO COMPLY WITH ALL OF THE TERMS AND CONDITIONS AND UNDERSTAND THAT I AM RESPONSIBLE FOR All COSTS OF PROCEDURES PERFORMED AT WATERFORD FAMILY DENTAL.

T.C.P.A

TELEPHONE CONSUMER PROTECTION ACT

"I give my express permission to Waterford Family Dental and its Affiliates or contractors to contact me for any purpose at the current or any future numbers that are provided for my landline telephone, cellular telephone or any wireless device including the use of automated dialing equipment, prerecorded voice, or text messages."

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Signature

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Date