

WALLS FAMILY DENTISTRY

Financial Policy

We are dedicated to providing you the best possible care, and we want you to completely understand our financial policies. We provide dental services in good faith with the expectation that we will receive payment for those services. The patient is ultimately responsible for all charges.

1. Insurance- If you provide the necessary information, we will file your insurance for you. Your insurance policy is a contract between you and your insurance company; we file your insurance as a courtesy to you. It is primarily your responsibility to see that your insurance company covers your bill. We will promptly handle any requests for information to facilitate claims.
2. Co-pays - Co-pays and deductibles will be due at time services are rendered. Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered” you will be responsible for the complete charge. Payment will be due upon receipt of a statement from our office. It is your responsibility to notify our office of any changes in home address, contact numbers, or insurance coverage.
3. Self-Pay - Payment is required at the time of service. For the convenience of our patients desiring extended credit, we accept Visa, Mastercard, Care Credit and Citi Health Card. If the patient/responsible party is unable to pay at the time of service they will be asked to reschedule their appointment to a time when payment can be made, or make payment arrangements with our financial counselor. All visits will be subject to final audit; you may be billed for any additional services provided.
4. Divorce or Separation- In the case of divorce or separation, the person who brings the child in for treatment is responsible for payment at time of service. The account will be in the name of the person who has custody.
5. Third Party Claims- We do not file workers compensation or third party claims. We will provide you with the information to file yourself, as self pay. Payment in full will be due at the time services are rendered.
6. Returned Checks- There will be a \$30 service fee for checks returned by the bank for any reason. Returned Checks, including the service fee, must be paid by cash, credit card or money order within ten working days from the date returned.

AGREEMENT TO PAY AND INSURANCE AUTHORIZATION:

I request and authorize Matthew Walls D.D.S. and staff, to provide me with dental services. I understand that I am personally responsible for the charges for the services that I receive. I agree to pay all reasonable attorney fees and collection costs incurred by Dr. Walls, if my account is not paid as agreed. As a patient (or guardian of a patient) I understand that this office does not acknowledge agreements between parents accepting or denying financial responsibility for services provided. We consider the guardian (custodial) parent to be responsible for payment of services rendered. I hereby authorize Dr. Walls and staff, to bill my insurance carrier and any other persons or parties who may be liable for payment of these services. I also authorize my insurance carrier to make payment directly to Dr. Walls.

Print Patient Name

Date

Signature of Patient (guardian if minor)

Date