OFFICE POLICIES

Patient Name: ______________________________________ **DOB**: _______________________

FINANCIAL POLICY

ALL CHARGES ARE THE PATIENT'S RESPONSIBILITY. Insurance plans differ from patient-to-patient depending on the elected coverage and individual policy. The dental procedure(s) we have outlined for your care MAY NOT be a covered benefit under your individual policy. **The insurance we have ESTIMATED** may **NOT** be accurate and the remaining balance, if any, remains the patient's responsibility. Please remember that your insurance policy is a contract between you and your insurance carrier. We are NOT a party to this contract, in most cases. **You should be aware that pre-determination or pre-authorization of benefits does not guarantee coverage.**

We will, **AS A COURTESY**, verify your eligibility/benefits and bill your insurance and help you receive the maximum allowable benefit under your policy. **It is ultimately the insurance company's response to your claim that makes the final determination of your eligibility and you are responsible to pay any portion of the charges not covered.**

PAYMENT IS DUE AT THE TIME OF SERVICE. We understand sometimes this is not feasible. If a payment plan is needed, please contact our staff and arrange that prior to your scheduled appointment time.

X ____ **X** __________________

Signature of patient (Parent or Guardian if Minor) **Date**

APPOINTMENT POLICY

Our goal is to provide the best quality of care and service. We put faith in you to keep your dental appointment. When we set up an appointment, a specific amount of time is reserved just for you. Each of our patients is important to us, so we **NEVER** double book appointments. When our patient misses their appointment, our talented team of providers sit idle. As a courtesy, an appointment reminder call or text is made two (2) business days prior to your scheduled appointment.

Any patient that fails to show or reschedule/cancel without giving proper notice (2 business days) will be considered a no show and charged an $80.00 fee per hour of scheduled appointment. The charge is non-negotiable. If you dispute this fee, Dr. Kaylee Wonder, DMD, reserves the right to terminate the doctor-patient relationship.

All no show fees **MUST** be paid prior to the next appointment in order to be seen.

Calling and leaving a message to reschedule or cancel your appointment after normal business hours (Monday to Thursday 8-5pm) **will not be accepted** as proper notice.

A deposit of $80.00 per hour is **REQUIRED** for any appointments reserved for 2 or more hours.

X ____ **X** __________________

Signature of patient (Parent or Guardian if Minor) **Date**

please see other side

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I understand that services rendered to me by Wonder Family Dental & Dentures are my financial responsibility and that the dentist will bill my insurance company as a courtesy. **I authorize my insurance company to pay my benefits directly to Dr. Kaylee Wonder and I understand that I will be fully responsible for any outstanding balance on my account.** As of today, I give Wonder Family Dental & Dentures (NPI: 1033630165) at the above address permission to access my Explanation of Benefits (EOBs) for the next three (3) years. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

I authorize Wonder Family Dental & Dentures to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Dr. Kaylee Wonder within 48 hours. I agree that if I fail to send the payment to Wonder Family Dental & Dentures and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

I authorize Dr. Kaylee Wonder to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

X ____ **X** __________________

Signature of patient (Parent or Guardian if Minor) **Date**

NOTICE OF STATEMENT OF PRIVACY PRACTICES

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Statement.

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

- ☐ Any member of the family
- ☐ Spouse only
- ☐ Others (please specify) ____

X ____ **X** __________________

Signature of patient (Parent or Guardian if Minor) **Date**