WONDER
FAMILY DENTAL & DENTURES

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FINANCIAL POLICY AGREEMENT

Patient Name:_____ **DOB**:_____

We, the staff of *Wonder Family Dental & Dentures***,** thank you for choosing us as your dentist. We consider it a privilege to serve your needs and we look forward to doing so. ***We are committed to providing you with the highest level of care and to building a successful dentist-patient relationship with you and your family.*** We believe your understanding of our patients' financial responsibility is vital to that dentist-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact ***Dr. Kaylee Wonder*** or ***Jason Wonder*** *(our office manager)* at ***(360) 779-1566****.*

We believe this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients.

Please understand that payment for services is an important part of the dentist-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, ***full payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.*** On treatment involving laboratory fees (crowns, bridges, dentures, etc.), 50% of the total is due for the preparation date; the remaining balance will be due upon completion--usually two to three weeks. On extensive treatment you may prefer to secure a bank, credit union, or other third party financing for the entire amount and make payments to the lending institute. We offer special financing through *CareCredit Finance* who offer several payment options.

We make payment as convenient as possible by accepting (***cash, money order, MasterCard, Visa, CareCredit and in-state checks***). A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. ***Our goal is to provide quality care and service.*** Please let us know immediately if you require any assistance or clarification from anyone within our business.

Insurance

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.*** 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.*** We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. ***Even a pre-determination of services does not guarantee payment from your insurance carrier.*** We also require photo identification when accepting insurance information. ***It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan.*** Failure to provide all required information may necessitate patient payment for all charges. ***When insurance is involved, we are contractually obligated to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.***

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of- network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Specials and Discounts

Because we are a preferred provider for multiple dental insurance companies, ***it is illegal (according to Antitrust Law) for us to provide any discounts to patients without doing the same for the insurance companies.*** Writing off or discounting patient's balances could jeopardize our contract with all insurance carriers.

Refund & Overpayment Policy

When you have a negative balance in your account due to overpayment or when we owe you a refund, we will do so within 30 days after all the balance in your account has cleared and the insurance claims have been processed by your insurance. You may also choose to leave it in your account for future appointments. ***If you paid with a credit, debit or CareCredit card, a refund will be given back into that same card you used. If you paid with a check or cash, you will be given a check refund.*** You must be present in person to receive your refund. No exceptions can be made unless there is a special circumstance.

Divorce or Separation

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the patient authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Workman's Compensation & Personal Injury

If you are getting workman's compensation, we require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for

payment in full. If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition, we require that you allow us to bill you health insurance. In the absence of insurance, other financial arrangements may be discussed. Payments of the bill remains the patient's responsibility, we cannot bill your attorney for charges incurred due to a personal injury case.

Interests and Collections

Interest will be imposed on each item of your account if unpaid within 30 days of the time the item was added to the account which will be computed at the rate of one percent (1%) per month or twelve percent (12%) annual percentage. The minimum finance charge is $0.50.

If your account becomes past due, we will take necessary steps to collect debt. ***After 60 days, if the amount owed is not paid or there is no payment agreement in place, we will turn your account over to a collection agency where you agree to pay all of the collection costs that are included.***

Miscellaneous Forms, Additional Information, and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports, or extracurricular activities there will be an administrative fee, not to exceed $35.00, for additional information.

Missed Appointments

We require notice of cancellations 48 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. ***These fees are typically $80.00 (per hour scheduled) but not to exceed one-half of the cost of your scheduled appointment.*** Repeated missed appointments without notification may cause you to be dismissed from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, dentists also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries.

If you wish to transfer records, you will need to request in writing (we have a courtesy form you may use) and pay a copying fee ($20) if you want copies of your records sent to another doctor or organization. However, ***we will gladly send digital records free of charge as a courtesy.*** You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

I read and understand the above financial policy. I agree to assign insurance benefits to Wonder Family Dental and Denture if I utilize one or whenever possible. I also agree, in addition to the amount owed, I also well be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Patient or Responsible Party Signature: _____ Date:_____