Waushara Dental Associates S.C

Self-pay (No insurance): All fees are due in full at the time of service. We will provide a **three percent courtesy discount** for cash or check payments paid in full.

Insurance: We submit claims to all primary and secondary insurance carriers. Please remember that your insurance coverage is a contract between you and your carrier. You, the insured, are responsible for payment on any claims that are 1) denied, 2) unpaid due to deductible, 3) partially paid, or 4) specifically partially paid due to the carrier's arbitrary determination of "usual and customary" rates. If your carrier is a PPO or HMO and we are not a participating provider, we may require payment in full from you at the time of service as the insurance carrier may send the payment directly to you, not us. **All balances are due and payable upon receipt. Co-payments are due in full the day of service.**

We accept all major credit cards and CareCredit.

Minor Patients: Parents must accompany minor patients to their first dental appointment. For unaccompanied minors, non-emergency treatment may be denied unless full insurance information is provided or prior arrangements for full payment at time of service have been made.

Divorced/Separated Parents: Co-payment/payment is due in full the day of service by the presenting parent.

I, _____ understand will be responsible for any fees incurred during the process of bad debt collection.

I have read the Financial Policy and understand its contents. I agree to abide by the policy for all services provided by Waushara Dental Associates SC.

I hereby consent to any examinations, x-rays, diagnostic procedures, tests and/or treatment the doctor may prescribe. I understand if I refuse recommended treatment, I will be asked to sign off on the proposed service(s) thereby releasing the provider(s) from responsibility. I authorize release of any information, including diagnosis and the records of any treatment or examination given to me, to third party payors and/or other health practitioners as required and wish to assign benefits to Waushara Dental Associates. I give permission to use e-mail, text, post card or voicemail for communication purposes. I am responsible for any amount not covered by my insurance. I understand that payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that appointments broken or canceled less than 24 hours' notice may result in a charge.

Patient/Guardian Signature:_____

Date:_____