Waushara Dental Associates, S.C.

Thank you for choosing Waushara Dental Associates, S.C. for your dental care needs. We appreciate your trust in us and the opportunity to serve you. In an effort to contain ever-rising costs, we have implemented the following Financial Policy. We require all patients to read and sign our Financial Policy prior to treatment. If you have any questions, please let us know. We will be happy to discuss our policy with you.

FINANCIAL POLICY

Routine Dental Care: All fees for routine dental services are due in full on the date the services are rendered. We will provide a **three percent courtesy discount** for cash or check payments paid in full on day of service.

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, 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.**

Discover/Master Card/Visa: Are available for payment of accounts at any time.

Care Credit/Springstone Financing: Is available with current Driver's License and Credit Card.

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 I 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, S.C.

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Signature of Parent or Responsible Party Date