



WolfEever Dental
Todd E. Ealy D.D.S.

FINANCIAL POLICY

This is a statement of our financial policy which we require you to read and sign prior to any treatment.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.

REGARDING INSURANCE:

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. We accept assignment of insurance benefits after you furnish us with your full insurance information and this is verified by your insurance carrier. Your deductible and patient portion are due at the time of service. Some of the services provided may be a non-covered service and not considered necessary by your dental carrier. You are responsible for payment of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS:

The adult accompanying a minor patient is responsible for payment in full. For unaccompanied minors, charges must be pre-authorized and payment must be arranged by the legal guardian to be paid at the time of service.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment directly to the dentist named above for the dental service benefits otherwise payable to me. **PLEASE INITIAL** _____

I UNDERSTAND THAT IF PERFORMED DENTAL SERVICES ARE NOT UNDER CONTRACT WITH MY INSURANCE CARRIER OR I HAVE MET MY CONTRACT LIMITATIONS, I AM RESPONSIBLE FOR THIS FEE. **PLEASE INITIAL** _____

MISSED APPOINTMENTS

We ask that you give us 24 hours notice for any canceled appointment. Once 2 scheduled appointments have been missed we will require you to pay for the appointment in advance before we can schedule you another appointment. We reserve the right to deny any future scheduling of appointments due to repeatedly missed, canceled, or late appointments. **PLEASE INITIAL** _____

UNPAID BALANCES:

I understand that any attorney fees, court costs, and collection fees become my responsibility and will be added to my account, should it become necessary. Returned checks will be subject to a fee of \$30 for each time they are returned.

PLEASE INITIAL _____

I HAVE READ THE FINANCIAL POLICY AND I UNDERSTAND AND AGREE TO THIS POLICY.

X _____ Date _____

Signature of patient or legal guardian if patient is a minor