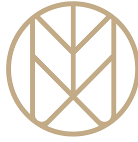

WHITE OAK
DENTAL

FINANCIAL POLICY

***It is required that patients read and sign this document prior to any treatment.** Our goal is to keep our prices as low as possible. If you have insurance, we will file it for you. If you do not have insurance, we accept cash and all major credit/debit cards. We will accept checks only from established patients, or if we are able to verify that funds are available.

Regarding Insurance:
Your insurance policy is a contract between you and your insurance company. White Oak Dental is 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.

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize payment directly to Dr. Brooks Pruehs of White Oak Dental for the dental service benefits otherwise payable to me. PLEASE INITIAL ________

I UNDERSTAND THAT IF THE DENTAL SERVICES PERFORMED ARE NOT UNDER CONTRACT WITH MY INSURANCE CARRIER, OR I HAVE MET MY CONTRACT LIMITATIONS, I AM FINANCIALLY RESPONSIBLE. PLEASE INITIAL ________

MISSED APPOINTMENTS:
We ask for notice of 24 hours to cancel an appointment. If two scheduled appointments have been missed, we will require advanced payment before scheduling another appointment. We reserve the right to deny future scheduling due to repeated missed, canceled, or late appointments. PLEASE INITIAL ________

UNPAID BALANCES:
If your account becomes past due, we will take necessary steps to collect this debt. I understand that attorney fees, court costs, and collection fees become my responsibility and will be added to my account, if necessary. Returned checks will be subject to a $30 fee for each time returned. Finance charges of 1.5% per month will be imposed on the unpaid balance after your account has gone 30 days past due. PLEASE INITIAL ________

CREDIT HISTORY:
We have the option to check your credit history and to report your account history to any credit reporting agency such as a credit bureau. PLEASE INITIAL ________

MINOR PATIENTS:
The adult accompanying a minor patient is responsible for payment in full.
PLEASE INITIAL (if applicable) ________

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)