Financial and Dental Insurance Agreement

We are committed to providing you with the best possible care. We need your assistance and your understanding of our payment policy.

- ***Payment of services is due at the time services are rendered***, unless our staff has approved other payment arrangements in advance. We accept cash, checks, Visa, MasterCard, Discover, American Express or Care Credit.
- As a courtesy, we call and/or text a few days before to confirm appointments. ***There is a $50 charge if you miss the appointment unless we are otherwise instructed by the doctors.***
- It is the patient's responsibility to have all records at our office prior to the appointment unless other arrangements have been made in advance.

We will gladly assist you with your insurance claims with the following understanding:

- As a courtesy to our patients, we will file your insurance claim and allow you to pay only your deductible and/or ***estimated*** portion as services are rendered. Please remember that the contract is between you and your insurance company, and your total balance in our office is always your responsibility.
- We make every effort to give you an accurate estimate of what your portion of our fees will be, based on information provided to us. However, we have no way to guarantee the actual term of your insurance policy. If for any reason there is a balance remaining after your insurance payment, you will be sent a statement. Disputes regarding reimbursement of the amount of reimbursement are between you and your insurance carrier.
- ***We are providers for Anthem and Delta Dental Premier but as a courtesy we file all other insurances (with the exception of Medicaid) with expected payment from patient at the time of service.***

Past Due Accounts

- Accounts that are 90 days past due will be turned over to a third party collection agency. We dislike doing this and will only do so if all other efforts to collect your unpaid balance have failed.
- At the discretion of the dentist, once your account is turned over to collections, if you need additional services after the account has been paid, you will be required to pay before any treatment is rendered.

I authorize release of any information relating to treatment and direct payment to White Cosmetic and Family Dentistry. I understand and agree that (regardless of my insurance status) I am ultimately responsible for all cost of dental treatment.

Patient(s) Name: _____

Signed (Patient or Responsible party) _____ Date: _____