Financial Policies

James T. Wolfe, DDS MSD accepts: **Cash, debit card, personal check, business check** (by an authorized person) **Credit Cards**; MasterCard, Visa, and Discover.

Care Credit: We have an outstanding financing company that provides our patients with an interest free loan for dental treatment (we pay the interest for you!). For treatment plans from $300.00, an interest free period for up to 12 months is provided. For larger treatment plans, we offer extended payment plans of up to 36 months (interest applies).

Dental Insurance: Our goal is to assist you in maximizing your benefits. Each company pays an insurance premium for specific coverage which fits the employer's budget. Each plan is different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments. We strive to estimate your out of pocket copay, but please understand that we are simply a third party interpreting your insurance plan as a courtesy.

Our expectations of you as the owner of the policy:

1) Payment of fees not covered by your insurance plan are due when scheduling treatment.
2) Please understand that the insurance policy belongs to **<u>you</u>** and we have no leverage to obtain payment from your insurance carrier.
3) Realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called UCR) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, *not* our fees or recommended treatment.
4) You will have to take responsibility for any fees your insurance has not covered after 30 days.
5) I hereby authorize Dr. Wolfe and any associates to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Wolfe. I understand I am responsible for all charges associated with this account and that interest charges of 1.5% per month will accrue on unpaid balances and a statement charge of $5.00 will be added to subsequent statements

I acknowledge my credit card will be securely registered and only charged balances not paid by insurance. Please choose the maximum amount you authorize to be charged:

- o $100 **Visa/MC/Discover (circle one)**
- o $150
- o $200 _____ Exp Date _____ CVV_____
- o Any amount

Appointment Guidelines

- Please call to let us know if you will be late, and give us an estimated arrival time. At this time, we may need to reschedule your appointment.
- **We require 24 BUSINESS HOURS notification for any rescheduling or cancellation of appointments. Failure to give adequate notice or missing a dental cleaning appointment will result in a $50 failed appointment fee. There may be additional charges if a dental procedure is missed or rescheduled with less than a 24 hour notice.**
- We will make a courtesy call 2-3 days prior to your appointment. If we have not heard back from you within 24 hours prior to your appointment, we reserve the right to offer your appointment time to another patient.

_____ _____
(Print Responsible Party or Patient Name) (Date)

_____ _____
(Signature Responsible Party or Patient Name) (Date)